1301. TOM Chapter 12, Section 1, Item 4.2 states that the contractor shall effectively distribute quarterly provider newsletters and monthly bulletins to all providers, Congressional offices, BCACs, DCAOs and HBAs. In current contracts, distribution of education materials to TRICARE-certified, non-network providers is focused on high volume, non-network providers and based upon claims paid in the previous 12 months. This method appropriately focuses distribution of materials to those non-network providers who see TRICARE patients, as non-network providers outside of this high volume group have little interaction with TRICARE beneficiaries (typically one or two claims per year). Is it the government's intent to incur the expense of having the MCS contractor distribute newsletters and bulletins to all non-network providers, even those who rarely see a TRICARE patient? (Note that the distribution of beneficiary newsletters and bulletins [TOM Chapter 12, Section 1, Item 4.3] is focused on TRICARE Prime enrollees who will receive a majority of their care from MTF and network providers.)

RESPONSE: Yes

1302. TOM, Chapter 7 (Utilization and Quality Management) Section 1, paragraph 3.0, Reviewer Qualifications and Participation requires that all initial denial determinations be made by a reviewer who is a practicing peer of the same or similar specialty as the provider who proposed or furnished the service.

a. Is our assumption correct that this requirement only applies to denials that are based on medical necessity and appropriateness of care?

RESPONSE: Yes.

b. Please clarify if this requirement also applies to medical review of claims versus authorization determinations.

RESPONSE: This requirement applies to medical review of claims as well as to authorization determinations.

c. This RFP recognizes the importance of utilizing commercial best practices when practical. National Accreditation Standards such as URAC and NCQA include standards that deal with medical necessity reviewer qualifications. Neither of these nationally recognized accrediting organizations require initial medical necessity decisions be made by practicing peers. TRICARE also has existing standards related to initial utilization management and claim reviewers which are currently utilized by incumbent MCS Contractors (reference TOM, Chapter 7, Section 1, paragraphs 2.3 and 2.4). These standards allow for medical necessity denial decisions by medical professionals with the appropriate education, training, and current licensure, but who are not in active clinical practice. Input is sought from physician reviews of the appropriate specialty when the expertise of these individuals is warranted. Additionally, prior to the issuance of an initial prospective medical necessity denial determination, the requesting physician is offered the opportunity to discuss the proposed denial with the physician advisor. It is critical that reviewers have a thorough knowledge of TRICARE medical policy and program criteria. A physician reviewer with active clinical practice is not going to have the level of knowledge regarding the TRICARE program as would a contractor's physician advisor. We are not aware of any evidence of problems associated with the use of these medical professionals for medical necessity decisions. We feel the imposition of the requirement for practicing peer review for all initial medical necessity denials will add

significant cost without commensurate benefit. Would the government consider retaining the current contract standards for initial medical necessity reviewer qualifications?

RESPONSE: No. The TRICARE regulation at 32 CFR 199.15(g), requires that TRICARE PROs (T-NEX contractors are considered multi-function PROs) establish and follow procedures for initial determinations that are substantively the same or comparable to the procedures applicable to Medicare under 42 CFR 466.83 to 466.104. Section 466.98(a)(1) (renumbered as section 476.98(a)(1)), requires that reviewers have "…active staff privileges in one or more hospitals in the PRO area." The TRICARE requirement that reviewers have an active clinical practice in the PRO area is substantively the same and comparable to the Medicare requirement and, we believe, less stringent than the Medicare requirement.

1303. TOM, Chapter 7, Section 1, paragraph 3.5, Administrative Requirements, requires that each UM review include the signature and legibly printed name of the reviewer. In conversations with outside peer review organizations, concern was expressed with this new requirement. The concern is with the potential that the identity of the reviewer may be released to beneficiaries and requesting physicians. Would the government consider an alternative approach, such as the assignment of a unique identifier to each reviewer, with this identifier indicated on each review? Upon request by TMA, the reviewer's Professional Qualifications Form could be provided, which includes all of the information called out in TOM, 7, 1, 3.5.

RESPONSE: We disagree that a unique identifier is needed. Under TRICARE, the identity of the reviewer can be released to beneficiaries and requesting physicians (subject to HIPAA requirements, the Privacy Act and other legal requirements). This is not a new requirement. Please refer to the current MCSC Operations Manual, Chapter 13, Section 3, paragraph 4.2.2., where it is stated with respect to utilization review staff reviews: "The review shall be dated and include the signature and legibly printed name of the reviewer, and clinical specialty, (e.g., DO, MD)."

1304. TOM, Chapter 13, Section 4.1 - Reference previous response to question 836 which indicated that TMA was in the process of revising TOM, Chapter 13, Section 3, paragraphs 4.1.1 through 4.1.5 to more clearly state peer review requirements. More specifically, this response indicated that in cases where no clinical issues are involved, the reconsideration determination may be made by other than a peer reviewer. The response went on to confirm the assumption that in a situation where a medical necessity determination is fully favorable, the determination may be made by a first level reviewer (RN or physician assistant) or a second level reviewer (board certified physician). Change 3 to the TRICARE Operations Manual does include a change to Chapter 13, Section 4.1 however the change does not clarify the peer review requirements in these situations. Does the government intend to issue further changes to this section?

RESPONSE: No. The revisions to the TOM, Chapter 13, Section 3, Paragraph 4.0, appearing in Change 3 are in lieu of the revisions contemplated in our previous response referenced in you question. The requirements in Paragraph 4.0 apply only to appeal cases arising from determinations subject to the provisions of 32 CFR 199.15. The TOM is silent as to reviewer requirements in other cases, for example, cases involving factual determinations. Therefore, your comments relating to first and second level reviewers (including RNs and PAs) that issue initial determinations

being allowed to issue favorable reconsideration determinations, are no longer applicable (i.e., Paragraph 4.1 requires review by a specialist).

1305. Section L.14.e.(4), Subfactor 4: " Ensure that all services and systems are fully operational at the start of health care delivery. Disruption to beneficiaries and MTFs shall be minimized."

During the oral presentation, offers are to present a brief description of and timeline for the major start-up activities, specifically focusing on the staff hiring and training schedule and demonstrate that this schedule will result in adequate, trained human resources to achieve the objective as stated in Subfactor 4.

What is the Government's role in ensuring that disruption to the beneficiaries and MTFs are minimized? Transitioning 12 existing and long-standing regions during a 10-month period into 3 newly aligned regions is very aggressive and unprecedented in DoD operations. Along with the realignment of regions, the Government has chosen to carve-out key elements of the TRICARE program and procure them separately on a national level. Additionally, other services, such as beneficiary appointing services, must now be contracted at the local level. All contracting and transition efforts must be done within the specified 10-month time period in order to avoid major disruption. While offerors can speak to the requirements of Subfactor 4, they cannot speak to any transition issues associated with the carved out services. How will the Government ensure that these transitions take place? If a transition should falter or fail altogether, does the Government have an alternate plan in place to avoid any disruption of services?

RESPONSE: The Government will manage all contractors to ensure the transition occurs on schedule. This requirement speaks to those activities controlled by the MCSCs as reflected in their contract.

1306. Section C-7.1.10 states the following, "As a condition of participation in the contractor's network, all providers shall submit all claims electronically. The Regional Administrative Contracting Officer may grant an exception to this requirement based upon a fully justified written request from the contractor demonstrating that it is in the best interest of the Government to grant the exception."

a. In Question 101, the Government indicated that the justification for an exception to electronic claims submission would have to demonstrate "extreme necessity" for a retention of the provider in the network. We seek clarification as to what would be considered adequate justification for an exception to be granted. As an example, in rural areas a small number of providers may be willing to contract with TRICARE while other providers in that same 30/60 minute access area are not. However, the providers will only contract if the electronic submission requirement is waived. Going outside the access standards could have a detrimental impact on beneficiary healthcare and offering Prime in rural areas is in keeping with providing a uniform benefit to all TRICARE eligible beneficiaries. Would this situation, and other such similar ones, classify as "extreme necessity"? If not, please define "extreme necessity".

RESPONSE: A situation where no providers will contract with the MCSC in a required Prime Service area simply because of the EMC requirements will qualify if the MCSC has acted appropriately in attempting to contract with the provider. "Appropriately" may include incentives offered to the provider.

b. In Question 361, clarification was requested as to the type of documentation the Government is expecting to accompany waiver requests for electronic submission. The Government advised the contractor must document that specific attempts have been made to get the provider to send claims electronically. Attempts, according to the Government's response, include offering a computer and training. In Question 362 the Government used the term "proper incentives" to get providers on the "EMC bandwagon".

In Question 1219, TMA responds to a another question regarding incentives by quoting the following Public Law 106-65, Section 713(c): "The Secretary of Defense shall require that new contracts for managed care support under the TRICARE program provide that the contractor be permitted to provide financial incentives to health care providers who file claims electronically." These financial incentives, considered administrative costs, may be in the form of cash payments, the provision of software or hardware, payments to clearing houses on behalf of providers or other incentive rewards.

The Government further states that if an offeror elects to propose incentives, the dollar amounts are to be included in the per member per month CLIN. With all of these possible incentives that a contractor can offer, does the Government have a list of appropriate incentives that would need to be offered prior to the Government granting a waiver? If the offeror proposed certain incentives in the per member per month CLIN but excluded others that the Government ultimately determined should have been included, would the government require the contractor to offer the initially excluded incentives? If yes, at whose expense would these additional, and undefined, incentives be offered? The list of incentives is endless. The offeror is requesting a government "reasonable logic" statement for guidance.

RESPONSE: The Government does not have a list of incentives; rather, offerors are encouraged to employ their best practices in determining which incentives will fulfill the contract's objectives and requirements. The Government will not direct contractors to change the terms of the contract without following the change order process which may result in additional payments to the contractor.

c. The Government's response to Question 101, which raised the issue of paper claims, states, "We are not aware of any remaining Government required claim attachment."

Question 1183, also raises the issue of paper claims and makes the following statement:
"In the recent TMA EMC Workgroup meetings, the government identified 12 categories of claims where TRICARE policy requires some type of supporting documentation to be filed with the claim."

If this is a correct statement, which is in direct conflict with the Government's response to Question 101, please advise how we are to handle claims submitted by network providers that will be impacted by supporting documentation. Currently, claims that require supporting documentation must be submitted on paper.

RESPONSE: The quote is an offeror's question to which the Government responded that we do not agree with the assessment in light of the requirements in this RFP. The assessment, for instance, focused on TPL which is not submitted with the claim;

OHI information that can be accepted based on the information included in an electronic submission, and utilization management requirements that are under the control on the contractor or accomplished through preauthorization and concurrent review. In those few remaining instances, the RFP allows claims to be received electronically and later developed.

d. Question 362 provided the following statement: "At the claims processing improvements meetings in May, 2002, TMA presented industry comparison data that showed that the national average for EMC submissions for all health plans was 40%, and that data appears to have included pharmacy."

The Government's response does not comment on the 40% figure, either the accuracy of the number or in relation to the 100% electronic claim submission requirement applicable to all network providers under T-Nex. Is 40% accurate? If accurate, what percentage are pharmacy and facilities?

Can the Government provide an understanding as to why they think an expected 60+% increase in electronic claim submission over the national average is (1) achievable in relation to maintaining access to network care and (2) why providers would be willing to change their practice management systems to meet this TRICARE requirement when they are not doing so for commercial insurers who reimburse at a higher level?

RESPONSE: As explained previously, the Government does not believe that historical levels represent an accurate picture of the future. The future includes HIPAA and web based submissions that eliminate the historical barriers as well as networks that must be properly sized and managed. Further, the Government must consider its fiduciary duty when our recent experience demonstrates that the cost of processing a paper claim is many times that of an electronic claim.

e. In July, a decision paper was presented to the TMA EMC committee regarding the conversion of TRICARE-Medicaid dual eligible claims to electronic submission. The paper included a recommendation that TMA should work with Medicaid State Agencies that submit the most paper claims, encouraging them to convert to 100% electronic submission of all types of claims. This is a solid and sound recommendation. Why for it's own program, does TMA insist on 100% electronic submission for all network providers instead of applying the same logic and focusing on high volume providers first and then continue to move the entire program to electronic submission?

RESPONSE: Please see our prior response.

f. Question 564 raised the issue of providers located in rural and underserved areas where TRICARE beneficiaries are located. The Government response stated: "Since networks only exist where there is a concentration of TRICARE beneficiaries and since the standard of practice has moved and continues to move toward the electronic age, we believe this requirement is appropriate."

This statement does not resolve the issue of the rural and underserved areas nor is it accurate. TRICARE beneficiaries do live in these areas. Network providers can currently be found in these areas. However, access to network providers will most likely be impacted when 100% electronic claims submission becomes an absolute

requirement. If the Government disagrees that their response to Question 564 is inaccurate please advise how this is an accurate statement.

RESPONSE: We disagree with your assessment as Prime in only required in catchment areas, BRAC sites and surrounding clinics servicing concentrations of military personnel. Further, we stand by our statement that the standard of practice has moved to and continues to move to fully electronic transmission of claims. We believe that is demonstrated by the work of the uniformed billing committees, congressional direction and the implementation of HIPAA. The Government is attempting to measure EMC submissions in all areas. IF not feasible in a given area, then a waiver will be granted.

g. Question 898a addresses Public Law 107-203. We believe this should be Public Law 107-105. Section 3 of PL 107-105, introduces the requirement of electronic submission of claims to Medicare.

Subsection (a)(22) states the following:
Subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary.

Subsection (h)(1):
The Secretary--
shall waive the application of subsection (a)(22) in cases in which--
there is no method available for the submission of claims in an electronic form; or
the entity submitting the claim is a small provider of services or supplier; and
may waive the application of such subsection in such unusual cases as the Secretary finds appropriate.

Section 3 further provides the following definitions:
For purposes of this subsection, the term `small provider of services or supplier' means--
a provider of services with fewer than 25 full-time equivalent employees; or
a physician, practitioner, facility, or supplier (other than provider of services) with fewer than 10 full-time equivalent employees.'.

While the TRICARE program does not follow law enacted for the Medicare program, a waiver similar to the above language could easily be applied to providers who service a limited number of TRICARE beneficiaries in rural areas, providers with limited staff, or providers who experience limited TRICARE beneficiary encounters. Efforts to move these "exception" providers to an electronic submission environment could be ongoing and in tandem with efforts to seek out other possible network providers who are willing to submit electronically. To ensure that the needs of all beneficiaries are met, would the Government reconsider applying similar language as being applied to Medicare to the TRICARE program? (end of 1306)

RESPONSE: We have considered your comments.

1307. The Government's response to Question 157 stated the following: "All current Resource Sharing and Resource Support projects will terminate with the expiration of the current contracts. The Surgeon's General are evaluating these initiatives and, where appropriate, will replicate current services provided under existing Resource Sharing and Resource Support provisions via means other than the Managed Care Support Contracts."

Will the review being conducted by The Surgeon's General be complete prior to the termination of the current contracts?

RESPONSE: Yes

If yes, for those projects that have been deemed appropriate, will the affected MTFs have enough time to replicate the services prior to the start of healthcare delivery under the new contracts?

RESPONSE: Yes

1308. Section L.14.e.(4) states that offerors are to provide a brief description of and timeline for the major start-up activities. Within this description, the offerors are to address how they will minimize disruption to beneficiaries and MTFs as well as specifically address how they will minimize the potential disruption caused by the expiration of all existing resource sharing agreements prior to or at the start of healthcare delivery.

Will the contractor be advised prior to the start of healthcare delivery what existing services will not be replicated to ensure that appropriate resources are available in the civilian network?

RESPONSE: In partnering with each MTF Commander, MCSCs will be advised of the capability and capacity of the MTF prior to the start of health care delivery.

1309. Reference H-5.d, Claims Processing Error Rates - The referenced paragraph describes an "Audit" process by which the Government intends to determine unallowable health care costs attributed to claims overpayment errors. The process presented in the RFP assumes a baseline performance level of zero overpayment errors and disallows all overpayment error costs.

a. Can the Government identify any current TRICARE claims processing system that has a zero percent error rate? Any commercial system?

RESPONSE: Offerors are encouraged to propose to the Government accurate claims processing systems rather than relying on the Government to identify such systems or assuming that the Government should pay for contractor errors.

b. If the Government cannot identify any claims processing system that experiences a zero percent overpayment error rate, does the Government believe this is a characteristic of either a world class health care delivery system (see C-2.1, Objective 2) or "best-offered" in the civilian community (See L-1, Overview)?

RESPONSE: This solicitation is consistent with the FAR, DFARS, and applicable acquisition/contracting laws. As with all cost-reimbursement contracts, the Government simply cannot reimburse a contractor for unallowable costs. All cost-reimbursement contracts have clauses that allow the Government to conduct audits to verify if payments made by contractors were for allowable costs; and provides the Government the rights to suspend payments, deduct from payments, recover funds, or otherwise protect the Government.

c. If zero percent overpayment error rate is not world-class or "best-offered", on what basis has the Government chosen to establish a zero percent tolerance?

RESPONSE: Please see our response to 1309b.

d. Under the Performance Guarantee provisions of the contract, the contractor is already subject to penalty assessments for over/under payment errors (H-8i) and under the risk sharing provisions the contractor is responsible for 20% of any overruns.

Please comment on:

(1) How the Government justifies a penalty provision based upon "disallowed" costs. In other words, if these costs are "disallowed", how can there be a performance penalty when no financial harm has accrued to the Government?

RESPONSE: There are no penalties. Rather, Section H requires the contractor to offer a performance guarantee to demonstrate that it will perform in accordance with its contractual obligation. It is very important to note that performance guarantees are never applied when a contractor is performing at the levels it agrees to in the contract.

(2) Why a 20% risk for overpayments is inadequate "incentive" to encourage accurate claims payment practices and a 100% disallowance is necessary.

RESPONSE: Please see our previous response. We believe that contractor's, acting in good faith, require no incentive besides the contract payment to which they agreed to fulfill their obligation.

1310. Reference C-7.21.18, Balance Billing - Question 689a clearly articulated the apparent dichotomy created by the requirements of this paragraph. Your answer did not address the inconsistency in requirements raised by the question. On the one hand, the TRICARE Policy and Operations Manuals specify the MCSC, for Prime enrollees referred to a non-network provider, shall protect the beneficiary from balance billing by paying up to 115% of CMAC for billed charges. On the other hand, this paragraph specifies that any payments in excess of CMAC shall be unallowable health care costs. The dichotomy is that the Government, in its specifications, recognizes that there inevitably are situations where the contractor may be required to pay higher than CMAC in order to provide appropriate and accessible medical care for beneficiaries yet declares these properly incurred costs are not allowable for reimbursement. These apparently conflicting requirements will result in unnecessary administrative costs to the Government to modify the claims processing systems (including TEDS) to handle this unique payment arrangement. This requirement may result in additional administrative costs either to develop overly robust networks to avoid any referrals to non-network providers or to include other administrative pricing methods to offset the liability of these unallowable health care costs. Further, a contractor could conceivably reduce service levels by channeling referrals to providers more distant to the beneficiary or to providers with longer wait times for an appointment solely in order to avoid this liability. Based on analysis of the historical claims data provided, it appears the potential increase in administrative costs may exceed the unallowable health care costs.

a. Will TMA consider amending the RFP to delete the last sentence of paragraph C-7.21.18?

RESPONSE: No, we disagree with your assertions. The RFP is structured to protect the beneficiary from incurring unnecessary out of pocket expenses while providing motivation to the contractor to establish adequate networks.

b. If not, will TMA consider modifying the TRICARE Manuals to remove the requirement pay 115% of CMAC in this situation?

RESPONSE: We have considered and rejected your suggestion.

c. If the answer to a. and b. is no, can the Government explain how they can specify an authorized claim payment amount and then disallow those costs?

RESPONSE: The Government is simply protecting our beneficiaries from incurring unnecessary out-of-pocket expenses while providing an incentive for contractors to operate comprehensive networks.

1311. Reference G-3.a and G-3.b - Underwritten Health Care Reimbursement

The RFP divides payment for underwritten health care costs into two separate processes – payment by TMA (G-3.a.) and payment by MTFs (G-3.b.).

- The provisions of G-3.a apply to all Standard and Extra claims as well as claims for Prime enrollees with a civilian PCM. For these health care costs, the TMA will reimburse the contractor within 5 workdays of an accepted TEDS. This represents 63% of the national Prime enrollee costs in the annual claims data furnished by TMA.
- The provisions of G-4.a. apply to all claims for Prime enrollees with an MTF PCM. For these costs the contractor is required to submit a monthly invoice to each MTF 10 days after the end of each month for the TEDS accepted by TMA the during the month. The MTF pays in accordance with the Prompt Payment Act, which allows the Government up to 30 days after receipt to make payment. The contractor will be required to carry the health care costs for these claims from 40-70 days after payment of the health care claim before reimbursement. This represents 37% ($1.1B annually) of the national Prime enrollee costs in the annual claims data furnished by TMA. A contractor will have to invoice scores of MTFs each month in order to receive payment and collectively the MTFs will have to process all of these invoices.

a. What is the rationale for having two separate payment procedures for Prime enrollee health care costs, with one having significant adverse affects on contract financing?

RESPONSE: The purpose of having payments made by the responsible MTFs is to assure that responsibility for paying for care and authority to order care are correctly aligned within the direct care part of the Military Health System.

b. What value added do these two payment procedures bring to the administration of the contract. The G-4.a. provision creates a complex administrative process while causing an increase in the administrative price of the contract as well as increasing the cost to the Government for administration.

RESPONSE: See previous response.

c. Would the Government consider a revision to the payment provisions whereby TMA paid for all underwritten health care costs based on an accepted TEDS, and a reconciliation process between the MTF and the contractor, if required, could occur post payment based on detailed payment reports. Any internal Government funding processes could be transparent to the MCSC and thus the Government could avoid any related costs.

RESPONSE: See previous response

d. Are U.S. Coast Guard Clinics subject to the MTF invoicing requirements in paragraph G-4? If yes, will they use DFAS as a payment office? If not, are there different payment office invoicing procedures?

RESPONSE: All Coast Guard Clinic bills will be paid centrally rather than through the MTF invoicing process.

1312. Section B, Health Care Services CLINs, including Target Costs and Underwriting Fee -
The line items for Health Care Costs state that this line item is determined to be a Cost plus Incentive Fee element of the RFP and resulting contract. In comparing the nature of contractor responsibility, risk assumed and features of the incentive mechanism included in Section H-1 of this RFP to those same features in the existing MCS contracts, it is clear that they are virtually identical. For example:

- Target health care cost defined in H-1 b. (2) is equivalent to Health care budget in the current contracts.
- Target Underwriting Fee in H-1 b. (3) is equivalent to Health care profit in the current contracts.
- Minimum and Maximum Fee and Fee Determination in H-1 b. (4) and (5) are equivalent to the Equity at risk and Risk sharing corridors in the current MCS contracts.
- In both this RFP and the current contracts (prior to the Global Settlement), actual health care costs are subject to audit with potential disallowances. This RFP is more punitive in that only overpayments are extrapolated.

As described, this RFP maintains at least the same level of health care risk for the contractor as the existing MCS contracts. The normal approach in government contracts would have fixed price type contracts containing more contractor risk than cost plus type contracts. This RFP appears to reverse that relationship by placing higher risk in a cost plus contract.

What is the basis for classifying the Health Care line item of these contracts as "cost plus incentive fee" when the only substantive difference between the proposed contract and the current MCS contracts is the timing of payment to the contractors?

RESPONSE: The Government's requirements are specified in the solicitation, and we believe the contract line items are appropriately classified

1313. Sections M-5.b, M-8 and M-9

Section M-5(b) of the RFP states that "price is more important than cost" as an evaluation factor. Sections M-8 and M-9 provide additional information on how price and cost will be evaluated, including the fact that target underwritten health care costs will be proposed and reviewed for Option Period I only. Please explain and comment on the Government's relative evaluation in the following cost proposal situations.

a. An offeror can spend an additional $1 million annually on a utilization management program and demonstrate conclusively that health care costs will be decreased by $1 million annually as a result; the proposed target underwritten health care cost for Option Period I is reduced accordingly. The Government will calculate a total evaluated price that is $5 million higher and a cost that is less than $1 million lower, because of the phase-in of health care responsibility in the first year. A cost proposal without the additional utilization management will therefore be evaluated more favorably by the Government. Is this correct? Or, would such a cost proposal be evaluated less favorably? Or, would the cost proposal be evaluated the same with or without the U.M. change? Please explain the answer.

RESPONSE: The Government will evaluate proposals as specified in Section M of the solicitation. The hypothetical contains insufficient information on which to speculate as to the actions available to the Government. The Government can not say with certainty what action it might or might not take.

b. An offeror can spend an additional $1 million annually on a utilization management program and demonstrate conclusively that health care costs will be decreased by $5 million annually as a result; the proposed target underwritten health care cost for Option Period I is reduced accordingly. The Government will calculate a total evaluated price that is $5 million higher and a cost that is less than $5 million lower because of the phase-in of health care responsibility in the first year. A cost proposal without the additional utilization management will therefore be evaluated more favorably by the Government. Is this correct? Or, would such a cost proposal be evaluated less favorably? Or, would it be evaluated the same with or without the U.M. change? Please explain the answer.

RESPONSE: The Government will evaluate proposals as specified in Section M of the solicitation. The hypothetical contains insufficient information on which to speculate as to the actions available to the Government. The Government can not say with certainty what action it might or might not take.

c. An offeror can spend an additional $1 million annually on a utilization management program and demonstrate conclusively that health care costs will be decreased by $8 million annually as a result. After considering the phase-in of health care responsibility, the proposed target underwritten health care cost for Option Period I is reduced by $5 million. Thus, the Government will evaluate a price that is $5 million higher and a cost that is $5 million lower. Because price is more important than cost, a cost proposal without the additional utilization management will be evaluated more favorably by the Government. This means that an offeror should not include this utilization management change, even though it would be financially beneficial to the government; the price would be higher by $5M, but the costs would be lower by $37M ($5M in Option 1, $8M for each of Option 2 through Option 5). Is this correct? Or, would such a cost proposal be evaluated less favorably? Or, would it be evaluated the same with or without the utilization management change? Please explain the answer.

RESPONSE: The Government will evaluate proposals as specified in Section M of the solicitation. The hypothetical contains insufficient information on which to speculate as to the actions available to the Government. The Government can not say with certainty what action it might or might not take.

d. An offeror can spend an additional $1 million annually on a utilization management program and demonstrate conclusively that health care costs will be decreased by $16 million annually as a result. After considering the phase-in of health care responsibility, the proposed target underwritten health care cost for Option Period I is reduced by $10 million. Thus, the Government will evaluate a price that is $5 million higher and a cost that is $10 million lower. Would the offerors cost proposal be evaluated more favorably by including this change, or would the proposal be evaluated more favorably by excluding this change? Or, would inclusion or exclusion of this utilization management change have no effect on the government's evaluation of the cost proposal? Please explain the answer.

RESPONSE: The Government will evaluate proposals as specified in Section M of the solicitation. The hypothetical contains insufficient information on which to speculate as to the actions available to the Government. The Government can not say with certainty what action it might or might not take.

1314. Reference Government supplied data tapes. - In the West contract, with the health care cost data supplied by the Government, a reasonable "baseline" period of experience (i.e., allowing sufficient claims runout to estimate incurred amounts fairly accurately) for rating purposes would be April 2001 – March 2002. The end of the base period is thirty-six to twenty-four months prior to the start of Option Period I in the West Region contract. During this period, the possibilities of substantial changes in the number of individuals eligible for coverage, MTF services levels, and health care cost inflation are clearly apparent.

For example, the annual inflation rate could easily vary from 5-10%. On a baseline cost of $1 billion per year, this assumption alone would change the projected annual health care cost target by more than $170 million. Note that, because of the redetermination of the underwriting fee, this is a risk to the contractor and the Government.

a. What means has the Government considered to mitigate these risks? Would a retrospective adjustment mechanism be acceptable?

RESPONSE: The Government does not intend to change the solicitation. How an offeror accounts for risk in their cost/price proposals is at the discretion of each offeror.

b. Much of the risk would be eliminated with the use of a baseline period closer in time to the beginning of Option I, e.g., the preceding twelve months. The target cost could be estimated at the time of proposal submission and recalculated readily when the actual base period costs are known. Would the Government consider such an approach?

RESPONSE: The Government does not intend to change the solicitation. How an offeror accounts for risk in their cost/price proposals is at the discretion of each offeror.

c. The use of a more recent baseline also has the advantage of making the health care risk for the first year more similar to the later periods, when the target costs can be negotiated. If the Government will not accept this modified pricing approach, would a change to the risk sharing (redetermination of underwriting fee) be considered? For example, target fee could be adjusted by 5% of the cost differential in Option Period I instead of 20%. Or the contractor could bear an increasing share of the risk with each year (e.g., Option I – 5%; Option II – 10%; Option III – 15%; Option IV – 20%; Option V – 25%), etc. Please comment.

RESPONSE: The Government does not intend to change the solicitation. How an offeror accounts for risk in their cost/price proposals is at the discretion of each offeror.

1315. Please explain how the Government will adjust the Option I to Option II "national trend factor" described in §H-1b.(2)(c) to account for the differing impact of the changes that will occur with the start of health care delivery under the new contract.

RESPONSE: See responses to numbers 76, 316, 317, and 530.

1316. The Government has supplied only partial historical information about Resource Sharing and an estimate of current annualized expenditures and savings. If there are any anticipated changes in the program - expansion, contraction, or types of services provided - in the next two years (as a current contractor, we are aware that such is the case in our own area and have no reason to believe the same is not true in others) the incumbent will have an unfair competitive advantage in bidding. How does the Government plan to address this inequity?

RESPONSE: The Government disagrees there is an inequity. The Government has provided all interested parties the information it can in the solicitation or in responses to earlier questions. The Government does not know of planned material changes. Changes that are "anticipated" by a contractor are not certain; therefore, it is unreasonable to articulate such "anticipated changes" as fact to potential offerors. One potential offeror's speculation about the future does not give rise to unfair competitive advantage.

1317. The Response to Question 11 states that "Underwriting will no longer be a consideration as a prime or subcontractor." Also, the Response to Question 955 stated that "There is no restriction on underwriting." However, as of Amendment 0006, the current Section L.13.c (formerly Section L.12.c in RFP Amendments 0001 and 0002 and formerly Section L.11.c in the original RFP) has not been modified to provide that the underwriting of health care is not a consideration as a prime contractor.

a. When will Section L.13.c of the RFP be amended to provide that the underwriting of health care is not a consideration as a prime contractor?

RESPONSE: The Government does not intend to change the solicitation. Section L, paragraph L-13 c. clearly explains in what situations the Government will exclude potential sources.

b. When will Section L.13.c of the RFP be amended to provide that there is no restriction on underwriting?

RESPONSE: The Government does not intend to change the solicitation. Section L, paragraph L-13 c. clearly explains in what situations the Government will exclude potential sources.

1318. Question 398 asked "If a company bids as Prime on two contracts but can only be awarded one, if the contractor is the highest scored bidder on both, will the contractor be able to choose its contract or will this be a government-only decision?" Question 398 was a two-part question but the only Response to the two questions was "No".

a. Did the Response "No" apply to the first part of the question of "will the contractor be able to choose its contract"? If the Response "No" did not apply to the first part of the question, what is the answer?

RESPONSE: The answer applied to the first part of the question.

b. Did the Response "No" apply to the second part of the question of "will this be a government-only decision"? If the Response "No" did not apply to the second part of the question, what is the answer?

RESPONSE: This is a Government-only decision.

1319. Questions 442, 443 and 444 presented questions regarding the gap between the award of Base Period CLINs 0002, 0003, 0601, 0602, 1101 and 1102 and the start of work for those CLINs. Question 442 asked whether the contractor can commence transition work upon contract award of those CLINs and the TMA response to Question 442 was that "The contractor may make its own management decisions; however, the Government will not begin paying for transition activities until the 10-month transition period begins."

a. Please clarify what work for CLINs 0002, 0003, 0601, 1101 and 1102 TMA is officially authorizing (i.e., contractually obligating) the contractor to perform from the date of award of those CLINs to the start of the ten-month period specified for each of those CLINs.

RESPONSE: The transition-in CLINS are firm-fixed-priced, so commencing at the time of award of the CLINS, the contractors may perform whatever work is necessary to meet contract requirements. The Government intends to award all transition-in CLINS in each respective contract period at the same time (i.e. CLINS 0001, 0002, and 0003 will be awarded together).

b. The Base Period for the South contract is stated to commence on June 1, 2003 but CLIN 0601 for that task does not commence until October 1, 2003. By award of CLIN 0601, will TMA be officially authorizing (i.e., contractually obligating) the contractor to perform any work on CLIN 0601 during the period from June 1, 2003 to September 30, 2003?

RESPONSE: Yes. See a. above.

c. The Base Period for the South contract is stated to commence on June 1, 2003 but CLIN 0602 for that task does not commence until January 1, 2004. By award of CLIN 0602, will TMA be officially authorizing (i.e., contractually obligating) the contractor to perform any work on CLIN 0602 during the period from June 1, 2003 to December 31, 2003?

RESPONSE: Yes. See a. above.

d. The Base Period for the North contract is stated to commence on June 1, 2003 but CLIN 1101 for that task does not commence until August 1, 2003. By award of CLIN 1101, will TMA be officially authorizing (i.e., contractually obligating) the contractor to perform any work on CLIN 1101 during the period from June 1, 2003 to July 31, 2003?

RESPONSE: Yes. See a. above.

e. The Base Period for the North contract is stated to commence on June 1, 2003 but CLIN 1102 for that task does not commence until November 1, 2003. By award of CLIN 1102, will TMA be officially authorizing (i.e., contractually obligating) the contractor to perform any work on CLIN 1102 during the period from June 1, 2003 to October 31, 2003?

RESPONSE: Yes. See a. above.

1320. The Response to Question 446 stated that the Transition Out CLINs under Option Period I (i.e., CLINs 0108, 0611 and 1110) are Transition Out CLINs that are performed only if Option Period II is not exercised.

a. Are Transition Out services required if Option Period I is not exercised? If so, which Transition Out CLINs apply if Option Period I is not exercised?

RESPONSE: No. If option period 1 is not exercised, and if the Government requires additional services, it would require a change to the contract.

b. Section F.5.d(7), for example, requires Transition Out services starting 120 calendar days prior to the start of health care delivery of the follow-on contract. If Option Period I is not exercised and Transition Out services were required, the requirements of Section F.5.d(7) would have to be completed by the sixth month of the Base Period. Will the decision to exercise Option Period I (or the decision to require Transition Out services) be made by the end of the sixth month of the Base Period?

RESPONSE: Please see the previous response.

c. If Option Period II is not exercised and Transition Out services were required, the requirements of Section F.5.d(7) would have to be completed by the eight month of Option Period I. Will the decision to exercise Option Period II (or the decision to require Transition Out services) be made by the end of the eighth month of the Option Period I?

RESPONSE: The Government will make timely decisions.

d. The schedules in Section F.5.d indicate that some Transition Out services are required to commence as soon as either (1) 3 calendar days following contract award of the successor contract or (2) 120 calendar days prior to the start of health care delivery and are scheduled to end at least 210 calendar days after the end of health care delivery. To clarify whether RFP schedule requirements conform to the TRICARE Operations Manual for the schedule of transition activities, please include in the RFP the period of performance for each Transition Out CLIN.

RESPONSE: The Government does not intend to change the solicitation.

1321. The Response to Question 447 stated that the estimated quantities for each Claims Processing CLIN are based on the date of receipt of the claim (rather than the date of health care service, the date the claim is processed to completion or some other basis).

a. Since the estimated quantities for the Option Period I Claims Processing CLINs (0103AA, 0103AB, 0605AA, 0605AB, 0605AC, 1201AA and 1201AB) are based on the date of receipt of the claims, those quantities should include the run-out of non-network claims from the current MCS contracts. Please identify the estimated quantities of the run-out claims from the prior contracts (i.e., claims for dates of service prior to the start of health care delivery) that are included in the estimated quantities for each of the Option Period I Claims Processing CLINs.

RESPONSE: No, the Government will not provide estimates in this manner. Offeror's may make their own projections based on the Government provided data and processed to completion factors.

b. Since the estimated quantities for the Option Period II Claims Processing CLINs (0201AA, 0201AB, 0701AA, 0701AB, 0701AC, 1105AA and 1105AB) are based on the date of receipt of the claims, those quantities should include the run-out of non-network claims from the current MCS contracts considering the timely filing requirements for those claims. Please identify the estimated quantities of the run-out claims from the prior contracts (i.e., claims for dates of service prior to the start of health care delivery) that are included in the estimated quantities for each of the Option Period II Claims Processing CLINs.

RESPONSE: No, the Government will not provide estimates in this manner. Offeror's may make their own projections based on the Government provided data and processed to completion factors.

c. Since the run-out claims from the current MCS contracts will be non-network claims (or Standard beneficiary submitted claims), those claims will probably not be submitted electronically. Therefore, should the proportion of electronic claims in Option Periods I and II be less than 85% of the total estimated claims volume?

RESPONSE: No.

d. Since the estimated quantities for each Claims Processing CLIN are based on the date of receipt of the claim, the estimated quantities for the Option Period V Claims Processing CLINs must not include claims received after the end of Option Period V. What are the estimated quantities of claims that are expected to be received after the end of Option Period V (i.e., during Transition Out) for each Region?

RESPONSE: No, the Government can not provide this estimate. Offeror's may make their own projections based on the Government provided data and processed to completion factors.

e. If Option Period V is not exercised, will the claims processing costs for claims received after the end of Option Period IV, be (1) paid as part of the Option Period IV claims processing CLINs or (2) paid as part of the Option Period V claims processing CLINs?

RESPONSE: Option Period IV.

1322. Question 455 inquired about the difference between the term "world-class health care" which is used in Objective 2 (Section C.2.1) and the term "best value health care" which is used in Objective 3. The Response to Question 455 provided different definitions of the two terms.

a. The term "best value health care" indicates a trade-off between services that meet the highest standards (i.e., world-class health care) and cost. The Objective 2 requirement to deliver "world-class health care" conflicts with the Objective 3 requirement to deliver "best value health care" (i.e., high quality clinical and other related services in the most economical manner). Please explain how the contractor is expected to perform these conflicting objectives.

RESPONSE: We do not see this as a conflict, but rather the goal of every successful company. The key for bidders is to apply their business practices in a manner that achieves the highest quality of services in an economical manner. We recognize that this may not be the cheapest; however, the cheapest approach rarely achieves the highest level of quality. Quality is what the Government is purchasing.

b. Is TRICARE currently considered to be "world-class health care" or "best value health care"?

RESPONSE: TRICARE as any good organization always strives to improve both the quality of services delivered as well as the efficiency with which they are delivered. We trust that our contractors will operate in the same manner.

c. Is TRICARE currently considered to be "health care and associated services that meet the highest standards"?

RESPONSE: No, there is always room for improvement.

d. Are the standards specified in the RFP the "highest standards" of world-class health care? If not, is TMA requiring less than world-class health care?

RESPONSE: The standards expressed in the RFP are the minimum. Offerors are encouraged to propose higher standards where ever they believe higher standards are necessary to reflect the "highest standards" of a world-class health care program.

e. Please identify any health care system (other than TRICARE) that is currently considered to be "world-class health care".

RESPONSE: The Government does not have preconceived notions about potential offerors.

1323. Question 461 stated that, in Section F.3.a on Page 36, the phrase "If exercised,…" is used in reference to Option Periods II, III, IV and V but is not used for Option Period I. Why is Option Period I listed above the phrase "If exercised…" instead of below the phrase?

RESPONSE: Because it is very difficult for the Government to imagine a situation where a contractor would perform so poorly during the transition that the Government would terminate the contract at the end of the base period.

1324. Question 463 asked for clarification regarding the delivery date for the Network Development Plan required by Section F.5.c.(12). Section F.5.c.(12) states that the quantity is "1 Lot". Please clarify the Response to Question 463 to identify whether only one Network Development Plan is required under each contract or whether a Network Development Plan is required for each Geographic Area under each contract. If more than one delivery is required, please modify Section F.5.c.(12) accordingly.

RESPONSE: Only one comprehensive plan is required.

1325. Question 478 concerned Section G-3.a(3)(j), which provides for payment of Transition Out services "following completion of work". The Response to Question 478 stated that "Transition payments are monthly" and "We will be clarifying Section G-3 further in the next Amendment." As of RFP Amendment 0006, the provision for payment of Transition Out services (Section G-3.a(3)(j) has not been revised or clarified.

RESPONSE: The response to 478 that is quoted above is inaccurate – see Section G of the solicitation. We have to revised the answer to 478. The Government does not intend to change the solicitation.

1326. Question 479 addressed the provision in Section G-4 on Page 44 that the "Claims Processing" CLINs (CLIN 0103, etc) are ordered by delivery orders issued by TMA. The response to Question 479 stated that "Delivery orders are estimates of how many claims will be paid a claim rate within an Option Period regardless of fiscal year." The response also stated that "Unless directed by CM to stop processing, all claims that are submitted and accepted will be paid any related claim processing payments."

a. Although the response states that the quantity on the delivery orders will be an estimate, we assume that the quantity will be multiplied by the applicable claim rate to establish a delivery order price and the amount of funds obligated on the delivery order. Is that assumption correct?

b. Under the Anti-Deficiency Act (31 U.S.C. 1341) is the Contracting Officer prohibited from requiring the performance of work for which funds are not obligated?

c. Considering the Anti-Deficiency Act, is it correct to say that "Unless directed by CM to stop processing, all claims that are submitted and accepted will be paid any related claim processing payments." if the amount payable to the contractor, after

TEDs are submitted and accepted, will exceed funding obligated on the delivery order?

d. Considering the Anti-Deficiency Act, is the contractor authorized to (1) only incur claims processing costs up to the limit of the dollar amount obligated on the delivery order or (2) only receive the number of claims stated on the delivery order so that if all claims received result in acceptable TEDs the dollar amount obligated on the delivery order will not be exceeded?

e. Considering the Anti-Deficiency Act, is it correct that when the contractor incurs claims processing costs in the amount obligated on the delivery order, the contractor may stop work?

f. Considering the Anti-Deficiency Act, is it correct that when the contractor has submitted acceptable TEDs in the quantity stated on the delivery order, the contractor may stop work?

g. Considering the Anti-Deficiency Act, when the contractor meets the limits on the delivery order, how does the contractor handle (i.e., return or reject) subsequent claims that are received or claims that are in process?

RESPONSE: The response to question 479 was partially inaccurate, so the response will be revised, including deleting the language quoted in this question. In response to this question, the Government intends to order a sufficient number of claims and obligate sufficient funds to cover all claims a contractor appropriately processes. For additional details not directly addressed in this response, we suggest that potential offerors review the clauses 52.216-18, Ordering, and 52.216-21, Requirements, in the solicitation. Any additional details are best addressed in a post award conference between the Government and the successful offerors. Since any additional details are regarding contract administration and do not impact a potential offeror's proposal, we suggest a successful offeror ask detailed questions at the post award conference.

1327. Question 480 addressed the provision in Section G-4 on Page 44 that indicates that the "Per Member Per Month" CLINs (CLIN 0104 etc.) are ordered by delivery orders issued by TMA. The response to Question 480 stated that "These orders are not monthly and all Members are to receive services requested and required in the contract regardless of the number of services already supplied and/or Members served in that month."

a. We assume that the member per month quantity will be multiplied by the applicable rate per member per month to establish a delivery order price and the amount of funds obligated on the delivery order. Is that assumption correct?

b. Under the Anti-Deficiency Act (31 U.S.C. 1341), is the Contracting Officer prohibited from requiring the performance of work for which funds are not obligated?

c. Considering the Anti-Deficiency Act, is it a correct to say that "all Members are to receive services requested and required in the contract regardless of the number of services already supplied and/or Members served in that month."?

d. Considering the Anti-Deficiency Act, is the contractor authorized to (1) only incur costs for CLINs 0104, etc. up to the limit of the dollar amount obligated on the

delivery order or (2) only provide services for the number of member stated on the delivery order so that the dollar amount obligated on the delivery order will not be exceeded?

e. Considering the Anti-Deficiency Act, is it correct that when the contractor incurs costs for CLINs 0104, etc. in the amount obligated on the delivery order, the contractor may stop work?

f. Considering the Anti-Deficiency Act, is it correct that when the contractor has provided services for the number of members stated on the delivery order, the contractor may stop work?

g. Considering the Anti-Deficiency Act, when the contractor meets the limits on the delivery order, how does the contractor handle subsequent requests from members that are above the amount obligated on the delivery order?

RESPONSE *REVISED 30 December 2002.*

RESPONSE: The response to question 480 was partially inaccurate, so the response will be revised, including deleting the language quoted in this question. In response to this question, the Government intends to order a sufficient number of units and obligate sufficient funds to cover all member months. For additional details not directly addressed in this response, we suggest that potential offerors review the clauses 52.216-18, Ordering, and 52.216-21, Requirements, in the solicitation. Any additional details are best addressed in a post award conference between the Government and the successful offerors. Since any additional details are regarding contract administration and do not impact a potential offeror's proposal, we suggest a successful offeror ask detailed questions at the post award conference.

1328. The response to Question 486 stated that "If an option period is exercised, it includes the contract line item numbers under that option." According to that response, when Option Period I of the West Contract is exercised, CLINs 0101 through 0110 are thereby exercised. Therefore, what are the contractor's obligations under CLIN 0108 (Transition Out) when Option Period I of the West Contract is exercised?

RESPONSE: None

1329. Question 487 concerned Section I.106(c), which states that "The total duration of this contract, including the exercise of any options under this clause, shall not exceed 5 years and 10 months." The total duration of the contract should include the period for the exercise of "any options under this clause".

a. Are the Transition Out CLINs considered an "option under this clause", i.e., Section I.106(c)?

RESPONSE: The Transition Out CLINs are a part of the total performance period under the contract.

b. Is the period of performance required by Section I.105 considered an "option under this clause", i.e., Section I.106(c)?

RESPONSE: No

c. Is the maximum duration of the Transition Out CLINs included in the 5 years and ten months specified in Section I.106(c)?

RESPONSE: Yes

d. Is the maximum duration of the services required by Section I.105 included in the 5 years and ten months specified in Section I.106(c)?

RESPONSE: No

e. Even if calculation of the total duration of the contract, specified in Section I.106(c), does not require the inclusion of the maximum period of performance of Section I.105 and the period of performance of the Transition Out CLINs, what would be the total duration of the contract if those periods of performance were included?

RESPONSE: The period under I.105, 52.217-8 Option to Extend Services, is not included in the period of performance under I.106, 52.217-9 Option to Extend the Term of the Contract. The Government does not know if the extension under the first clause will be utilized; and if it is, how many times and how many months.

1330. Question 488 stated that Section I.108, which is currently (as of RFP Amendment 0006) numbered as Section I.107. The question stated that the Section contained provisions that were left blank and requested that TMA provide the missing information for subparagraphs (a) and (i). The Response to Question 488 stated that "The fill-in data for this clause will be forthcoming in a future amendment." As of RFP Amendment 0006 the missing information for Section I.108(a) and (i) have not been provided. Please explain.

RESPONSE: Amendment 0003 incorporated the fill-ins missing from the initial solicitation. Amendment 0003 also deleted clause 252.232-7007, Limitation of Government's Obligation (Aug 1993). Note that there are no clauses in the current solicitation that have paragraphs (a) and (i).

1331. Question 493 concerned Section L.12.f(2)(b) which is currently (as of RFP Amendment 0006) Section L.14.f(2)(b). That Section provides that "The Government will only consider experience gained within the last three years."

a. The sentence quoted above conflicts with the sentence that follows it which states that all relevant experience shall be submitted. If the Government will only consider experience gained within the last three years, the offeror may be prevented from addressing "all relevant experience", such as TRICARE Transition In experience. Please resolve this conflict.

RESPONSE: No conflict. Submit alll relevant information within the last 3 years.

b. The sentence quoted above also conflicts with another sentence that follow it which states that "The offeror may submit any experience it believes demonstrates to the Government the capability of the prime and subcontractors to perform the required administrative services." If the Government will only consider experience gained within the last three years, the offeror may be prevented from addressing "any experience it believes demonstrates to the Government the capability of the

prime and subcontractors to perform the required administrative services", such as TRICARE Transition In experience. Please resolve this conflict.

RESPONSE: The Government believes that the last years of its past performance is sufficient to obtain relevant performance data to make a risk judgment.

c. The Response to Question 493 did not address the following part of the question: "Please clarify whether (and how) the government will evaluate past experience and performance for Transition In services, since similar transition-in services under all seven current MCS contracts were completed more than four years ago and the Government will only consider experience gained within the last three years." Please respond to that question.

RESPONSE: We believe we did respond appropriately. The Government will not evaluate any past performance of the current contractors which is older than 3 years to include the area of Transitions.

d. Please clarify whether (and how) the government will evaluate past experience and performance for Transition Out services, since similar transition-out services under any TRICARE or CHAMPUS contract was completed more than three years ago and the Government will only consider experience gained within the last three years.

RESPONSE: The Government will not evaluate any past performance of contractors which is older than 3 years to include the area of Transitions.

1332. The Response to Question 501 states that "Alaska is included in Geographic Area 11." However, the Responses to Questions 3 and 451 include charts that show Alaska included with Regions 9, 10 and 12. Please note that Alaska is currently included in the MCS Contract for TRICARE Regions 9, 10 and 12 and the transition of Alaska concurrent with the transition of Region 11 will require a partial termination of the contract for Regions 9, 10 and 12. Please confirm the Response to Question 501 that it is the intent of TMA to transition Alaska concurrent with the contract for Region 11 contract (rather than with the contract for Regions 9, 10 and 12 in which it is presently included) and correct the charts included with the Response to Questions 3 and 451.

RESPONSE: The State of Alaska receives services through the Region 9, 10, 12 contract, but is managed by the Lead Agent in Region 11. The Transition for Alaska is with Regions 9, 10, and 12 as depicted on the chart provided in response to Question 3.

1333. Question 513, concerning Section L.12.g(4) (g), which is now (as of RFP Amendment 0005) Section L.14.g(4), Health Care Prices, requested the Government's projections of MTF workload during any or all of the Option Periods of the contracts. The Response to Question 513 stated that "The Government did not make any projections." However, the Government has previously made MTF workload projections for the bid price adjustments under the current MCS contracts and for budgeting purposes using the Resource Analysis and Planning System (RAPS) or successor systems. Unless the MTF workload projections have been discontinued, the data is again requested.

RESPONSE: The Government, under this solicitation, will not be making the requested projections.

1334. Question 518 stated that Section M.2 indicates that the government will evaluate offers for award purposes "by adding the total price for all options to the total price for the basic requirement." which conflicts with the evaluation process stated in Section M.8. The Response to Question 518 stated that "We intend to address any apparent conflict between M.2 and M.8 in an amendment to the RFP". As of RFP Amendment 0006, the conflict between Sections M.2 and M.8 have not been resolved. Please explain.

RESPONSE: The response to question 518 is partially inaccurate, so it is being revised. We disagree that there is a conflict between M.2 and M.8/M.9. The Government will not amend Section M.2 of the RFP given that this is an approved FAR clause deviation that is merely a summary (and not intended to restate the rest of Section M) concerning the exercise of options. Section M.8 (a) and (b) address the evaluation process and note that total evaluated price will consist of all proposed administrative support service prices and health care services underwriting fees for all option periods.

1335. Question 519 referred to Section M.7.c which states (in the sixth line and also in the eleventh line) that a past performance rating will be based on "the amount of past performance". Question 519 asked whether the amount of past performance that will be considered limited to the last three years, as stated in Section L.12.f.(2)(b), which is now (as of RFP Amendment 0006) Section L.14.f.(2)(b). The Response to Question 519 was "Yes". If Offeror A has 3 years of past performance, Offeror B has 6 years of past performance and Offeror C has 9 years of past performance, will all three offerors be considered to have an equal "amount of past performance" since the amount of past performance that will be considered is limited to three years?

RESPONSE: The "yes" in response to question 519 refers to "Is the amount of past performance that will be considered limited to the last three years…" The amount of past performance is not the issue. Rather, the Government is interested in how the offeror's past performance demonstrates the offeror's ability to successfully accomplish the requirements of this contract.

1336. Questions 680 and 874 refer to the requirement in Section C-7.28 to locate a senior executive within a 15 minute drive of the Regional ACO's office. The Response to Question 874 stated that "The Government's experience has demonstrated that having a senior contractor representative immediately available significantly adds to the partnering relationship and the ability of both the Government and the contractor to collaborate." However, the Response to Question 680 stated that the technical evaluation would not evaluate this requirement.

a. Since Section M.6.a requires the government to evaluate an offeror's proposed technical approach (and its proposal risk) to collaborative efforts with the government and since a senior contractor representative's location within a 15 minute drive of the Regional ACO's office "significantly adds to the partnering relationship and the ability of both the Government and the contractor to collaborate", please explain why the government will not include Section C-7.28 (and its proposal risk) in the technical evaluation.

RESPONSE: To have a senior contractor representative within a 15 minute drive time is a mandatory requirement that each contractor must comply with. There is nothing to evaluate that would provide additional value to the government.

b. If Section C-7.28 will not be included in the technical evaluation, please identify any other requirements in Section C that will not be included in the technical evaluation.

RESPONSE: Please see Amendment 6, attachment L-12 for the outline of those minimum items that will be addressed in the evaluation.

c. If any requirements in Section C are not included in the technical evaluation, please amend Section M of the RFP accordingly.

RESPONSE: Noted.

1337. Question 724 asked whether the Government will give an offeror access to the information the Government used to assess the offeror's past performance? The Response to Question 724 stated "If the Government develops additional negative information upon which the offeror has not had the opportunity to comment, the Government will provide such an opportunity."

a. At what point in the procurement process (e.g., before the submission of the Past Performance proposal, during the oral presentation, after the oral presentation but before award, or some other date) will the offeror have the opportunity to comment on such negative information?

RESPONSE: Before the award.

b. If the offeror's response to such negative information occurs after proposal submission, will the response be made by a revision in the offeror's past performance proposal?

RESPONSE: No, it will be treated as a clarification of the past performance information.

c. If the offeror's response to such negative information is to occur at the oral presentation, does the government intend to waive, only for that offeror, the Section L.14.d.(1) prohibition on addressing past performance in the oral presentation and intent stated in Section L.14.d.(6) that the oral presentation will not constitute discussions?

RESPONSE: The response is not a part of the oral presentation, but negative information will be in a written document forwarded to the contractor by the Contracting Officer and a written response will be requested.

1338. Questions 793 and 966 asked if (1) the offeror proposes a higher performance standard for a requirement specified in Section H.8 or a new performance standard to be added to Section H.8 and (2) the offeror can show the added benefit to the Government, would an offeror's technical proposal be scored higher compared to how the offeror's technical proposal would be scored if the offeror only proposed to meet the RFP minimum performance standard. We understand that the evaluators will review any proposed enhancement to the

performance standards and make an independent judgment as to the value of the proposed higher performance standard. However, the Response to Question 793 stated that, if an offeror proposed a higher performance standard, there is a "potential" for that to have a positive effect on the scoring but the higher performance standard will "definitely" be incorporated into the award document. In order for an offeror to conduct a cost/benefit analysis of any proposed higher performance standard, please respond to the following questions:

a. If the government evaluator makes an independent judgment that an offeror's proposed higher performance standard has value to the government, why is there is a only a "potential" for that to have a positive effect on the scoring?

RESPONSE: If the Government determines that the proposed higher standard has value, the added value will be appropriately consider in the scoring.

b. If the government evaluator makes an independent judgment that an offeror's proposed higher performance standard does not have value to the government, why will the higher performance standard "definitely" be incorporated into the award document?

RESPONSE: While it may not have value to the Government in the evaluation (e.g., process 95.1% of all retained claims to completion within 30 calendar days versus the standard of 95%), the offeror has proposed a higher standard, and if awarded the contract, the higher standard becomes that contractor's standard to meet.

c. Is it the intent of the government to require offerors, who propose higher performance standards than required by the RFP, to perform to such higher standards if the performance to such higher standards has no value to the government?

RESPONSE: Yes.

d. The Response to Question 966 quoted part of Section M-6, which stated that the Government "will consider offers that commit to higher performance standard(s), if the offeror clearly describes the added benefit to the Government." We understand that offers that commit to higher performance standards will be "considered" by the government; however, Section M is intended to inform offerors of how such an offer will be evaluated. Another sentence in Section M.6 provides that "Proposals will be evaluated on the basis of how well an offeror's proposed procedures, methods, and delivery of services meet or exceed the Government's minimum requirement." Does this last quoted sentence from Section M.6 apply to the evaluation of Section H.8? If the last quoted sentence from Section M.6 applies to the evaluation of Section H.8, would an offeror's technical proposal be scored higher (compared to how the offeror's technical proposal would be scored if the offeror only proposed to meet the RFP minimum performance standard) if (1) the offeror proposes a higher performance standard for a requirement specified in Section H.8 or a new performance standard to be added to Section H.8 and (2) the offeror can show the added benefit to the Government?

RESPONSE: H-8 is not being specifically evaluated. The procedures and methods in meeting the subfactors in Section M -6 are being evaluated as are the standards proposed by the offeror. Where added value is demonstrated to the Government, appropriate consideration will be granted the offeror.

1339. In Response to Question 1014, Amendment 0006 revised Section G-3.a[1] which now provides that "Since all claims must be processed within 180 calendar days, the Government will not pay the outgoing contractor the healthcare or administrative cost associated with claims not processed to completion within 180 calendar days from the cessation of health care delivery." Please clarify the revision to Section G-3.a[1] since it does not consider the fact that the outgoing contractor will continue to receive claims from providers who have up to one year from the date of service (which could be one year from the cessation of health care delivery) to file their claims.

RESPONSE: See the response to Question 1261.

1340. The Response to Question 1057 states that "There are no claim rate payments for adjustments." How is the contractor paid for processing adjustments to claims with a date of service that is prior to the start of health care delivery (i.e., adjustments to claims originally processed by the outgoing contractor)?

RESPONSE: : One claim rate payment per ICN, per contractor is the rule. Since the new contractor has not been previously paid for these claims (ICNs), they would receive a claim rate payment for an adjustment based on the scenario provided (even if the old contractor also received a claim rate payment).

1341. The Response to Questions 1058 and the Response to Question 1219 indicate that use of a claims clearinghouse to transmit an electronic claim is acceptable but the Response to Question 1105 indicates that the use of a claims clearinghouse is unacceptable. Please clarify those Responses.

RESPONSE: The use of a clearing house is acceptable for the receipt of non-standard EMC and conversion into the current HIPPA compliant claim (e.g. ANSI X12N 837). It is not acceptable for paper claims to be submitted to a clearinghouse or other vender to be keypunched/scanned in.

1342. Section D of the RFP is shown as "Page – 34". Should the page number be revised to "Page D 1" to be consistent with the page numbering of the remainder of the RFP?

RESPONSE: While you are correct that page 34 is also D-1, the page numbering was only changed when that section changed. Section D has not changed since the initial release of the RFP. This will be corrected when the contract is issued.

1343. Section J (List of Attachments) of the RFP, through Amendment 0006, lists Attachments 5, 6 and 7 as "Reserved". However, those Attachments are still included on the TMA website for the RFP version through Amendment 0006. Please clarify whether Attachments 5, 6 and 7 are included or excluded from the RFP.

RESPONSE: Attachments 5, 6, and 7 were removed in Amendment 4 from the RFP, updated, and placed in the TRICARE Systems Manual. .

1344. On November 22, 2002, TMA announced that the cut-off date for submission of questions regarding the RFP is Friday, December 6, 2002.

a. Will TMA accept questions, after the cut-off date, pertaining to Responses that were posted to the TMA website after the cut-off date?

RESPONSE: No.

b. Will TMA accept questions, after the cut-off date, pertaining to RFP Amendments that were posted to the TMA website after the cut-off date?

RESPONSE: No.

c. Will TMA accept questions after the cut-off date, pertaining to Responses or RFP Amendments that were posted to the TMA website within 48 hours of the cut-off date and time?

RESPONSE: No.

1345. The TMA website contains the following notice: "Please note that the responses to the questions are advisory in nature. The RFP as amended represents the Government's official position. Nothing stated in the responses to the questions changes the RFP. If there are conflicts between responses to the questions and the RFP, the RFP takes precedence." Many of the Responses state that a questioned provision in a Manual will be changed "in an upcoming amendment" or "in a future change". Will the Government assure offerors that all changes to Manuals that were referenced in Responses will actually be issued?

RESPONSE *Revised 19 December 2002*

RESPONSE: The solicitation is inclusive of all TRICARE Manual changes issued as of November 27, 2002 (the effective date of Amendment 0006). Offerors should prepare proposals based on the published changes. Any corrections to the manuals that are identified, but not yet corrected, will be published in manual changes after award.

1346. Section L.13.c states that "If a potential prime contractor submits the best proposal for more than one contract Region, the Government shall decide which one of the contracts to award to that prime contractor as determined to be in the best interests of the Government."

a. Section L.13.c pertains to the award decision rather than to proposal instructions, therefore why is Section L.13.c included in Section L ("Instructions, Conditions, and Notices to Offerors") instead of included in Section M ("Evaluation Factors for Award")?

RESPONSE: The information is included in Section L.13.c. to provide notice of the Government's decision to conduct a full and open competition under this solicitation after the exclusion of sources and conditions under which the exclusion of sources will occur. We will also include similar provisions pertaining to contract award in Section M in the next RFP amendment.

b. What is meant by the term "best proposal" as used in Section L.13.c?

RESPONSE: The provision advises offerors that it is our intent not to award more than one contract to a single prime contractor. In view of the question, we will

amend Section L.13.c. by deleting the last two sentences of the first paragraph and substituting the following:

"The selection of three different prime contractors will occur even if a potential contractor submits proposals for more than one contract Region and each of the proposals is evaluated as the best value for the Government for the contract Region of submission. In such a situation, the Government shall decide which one of the contracts to award to that potential prime contractor as determined by the Source Selection Authority as being in the best interests of the Government."

c. What are the evaluation criteria described in Section M.3 [the factors and subfactors, which are required to be identified in accordance with 10 U.S.C. 2305 (a)(2)(A)(i) and FAR §15.304], that will be used to determine the "best proposal" as that term is used in Section L.13.c?

RESPONSE: With the amendment to the Section L.13.c. noted in our response to Question 1346. b., the evaluation factors and subfactors to determine the proposal representing the best value for each contract Region are set forth under Section M.4.

d. Please explain the difference between the term "best proposal" as used in Section L.13.c and the term "proposal representing the best overall value to the Government" as used in Section M.3.a.

RESPONSE: See response to Question 1346.b.

e. If there is no distinction between the term "best proposal" as used in Section L.13.c and the term "proposal representing the best overall value to the Government", as used in Section M.3.a, please explain why different terms are used.

RESPONSE: See response to Question 1346.b.

f. What is meant by the term "as determined to be in the best interest of the Government" as used in Section L.13.c?

RESPONSE: The Source Selection Authority will select for award in each contract Region the proposal which is determined to be the best value for the Government for that contract Region and which the Source Selection Authority determines would be consistent with furnishing high quality health care in a manner that protects the fiscal and other interests of the United States. In determining whether a contract award is in the best interests of the Government, the Source Selection Authority shall take into account the decision to exclude sources for contract award. Section M will be amended to reflect this award process.

"M.3. Basis for Evaluation and Award

a. General

(1) This is a competitive source selection and will be conducted in accordance with the Federal Acquisition Regulation (FAR), applicable supplements, authorized deviations, and authority to award three contracts using full and open competition after exclusion of any one contractor from being awarded more than one contract under the solicitation.

(2) The Government has established a Source Selection Evaluation Board (SSEB) to evaluate proposals submitted in response to this Request for Proposal (RFP). Proposals will be evaluated by the SSEB using the evaluation factors and subfactors identified below. Proposals which are unrealistic in terms of technical capability or are unrealistically high or low in cost will be deemed reflective of an inherent lack of technical competence or indicative of a failure to comprehend the proposed contractual requirements and will be rejected.

(3) The source selection for each of the three contract Regions resulting from this RFP will be based on the proposal representing the best value (which will include the risk associated with the proposal) to the Government for each contract Region, as determined by the Source Selection Authority to be consistent with furnishing high quality health care in a manner that protects the fiscal and other interests of the United States. If the proposals evaluated as the best value for each contract Region could result in award of more than one contract to any one contractor, the Source Selection Authority shall assess the alternative selection of proposals, taking all contract Regions into account, and make the selection of proposals for award that, in the aggregate, the Source Selection Authority determines will provide the best value to the Government while protecting the best interests of the Government. In determining whether it is in the best interests of the Government to select a proposal for contract award, the Source Selection Authority shall exercise the authority to exclude any one contractor from being awarded more than one contract under the solicitation and shall assess the alternative selection of proposals determined appropriate to reduce the risks to stability in administration of the TRICARE program, to the continuous availability of health care services for TRICARE beneficiaries, and to the fiscal interests of the Government."

g. What are the evaluation criteria [the factors and subfactors that are required to be identified in accordance with 10 U.S.C. 2305 (a)(2)(A)(i) and FAR §15.304] that will be used to determine the "proposal representing the best overall value to the Government" as that term is used in Section L.13.c?

RESPONSE: See response to Question 1346.f.

h. Please explain the difference between the terms "as determined to be in the best interest of the Government" as used in Section L.13.c and the term "proposal representing the best overall value to the Government" as used in Section M.3.a.

RESPONSE: See responses to previous subparts to Question 1346.

i. If there is no distinction between the term "as determined to be in the best interest of the Government" as used in Section L.13.c and the term "proposal representing the best overall value to the Government" as used in Section M.3.a. please explain why different terms are used.

RESPONSE: See responses to previous subparts to Question 1346.

j. If the Government receives only two proposals for a Region, will either or both offerors not be considered for award of the other two Regions?

RESPONSE: Section L.13.c. gives notice that the Government will award three contracts to three different prime contractors under this solicitation.

k. Are there any circumstances where the Government will award two contracts to the same prime contractor? If yes, please amend Section M accordingly.

RESPONSE: See response to Question 1346.j.

l. If the Government receives proposals for each of the three Regions from only two offerors, will the Government award two contracts to one of the offerors? If yes, please amend Section M accordingly.

RESPONSE: The Government is not anticipating this hypothetical event occurring. Please see response to Question 1346.j.

m. Will the Government eliminate an offeror from consideration for award of a Region (because that offeror will be awarded another Region) and award the contract to a second-ranked offeror if that second-ranked offeror has proposed a technical proposal that has been determined by the Government to be marginally acceptable or unacceptable?

RESPONSE: See response to Question 1346.f.

n. Will the Government eliminate an offeror from consideration for award of a Region (because that offeror will be awarded another Region) and award the contract to a second-ranked offeror if that second-ranked offeror has proposed a price that has been determined by the Government to be unrealistic or unreasonable?

RESPONSE: See response to Question 1346.f.

1347. Section M.3 states that "The source selection resulting from this RFP will be based on the proposal representing the best overall value to the Government."

a. Please confirm that the factors and subfactors that will be used by the Government to determine "the proposal representing the best overall value to the Government", which are required to be identified in accordance with 10 U.S.C. 2305 (a)(2)(A)(i) and FAR §15.304, are specified in Section M.

RESPONSE: See response to Question 1346.c.

b. Will offerors' proposals for each Region be evaluated independently from proposals for other Regions so that the evaluation of each Region stands on its own?

RESPONSE: Offerors proposals for each Region will be evaluated separately from proposals of other regions. However, when considering an offeror for award, the Government may consider any risk created by a subcontractor to multiple prime contractors.

c. Will offerors' proposals for each Region be ranked independently from proposals and awards for other Regions so that the ranking of proposals for each Region stands on its own? If no, please explain and modify Section M accordingly.

RESPONSE: Recommendations to the Source Section Authority for each Region will be made separately and independently from other regions. See response to Question 1346.f. regarding the Source Selection Authority selection of a proposal for award.

d. Will the proposal risk assigned to an offeror's proposal vary depending on which offeror is selected for award in another Region? If yes, please explain and modify Section M accordingly.

RESPONSE: See responses to Questions 924 and 1346.f.

e. Will the proposal risk assigned to an offeror's proposal in one Region vary depending on whether the offeror's proposed subcontractor in that Region is also a proposed subcontractor for an offeror that is selected for award in another Region? If yes, please explain and modify Section M accordingly.

RESPONSE: See responses to Questions 924 and 1346.f.

f. Will an offeror's proposal for any Region be re-evaluated or re-ranked, in any way, based on the decision to award a contract to another offeror? If so, please explain ands modify Section M accordingly.

RESPONSE: See responses to Questions 924 and 1346.f.

g. Please identify the factors and subfactors in Section M that the Government will consider in determining which Region will be awarded the first prime contract. Please modify Section M accordingly.

RESPONSE: See responses to Questions 924 and 1346.f.

h. Please identify the factors and subfactors in Section M that the Government will consider in determining which Region will be awarded second prime contract. Please modify Section M accordingly.

RESPONSE: See responses to Questions 924 and 1346.f.

i. Please identify the factors and subfactors in Section M that the Government will consider in determining which Region will be awarded the last prime contract. Please modify Section M accordingly.

RESPONSE: See responses to Questions 924 and 1346.f.

j. Please identify the factors and subfactors in Section M that the Government will consider in determining which offeror will be awarded a prime contract for the first Region and excluded from consideration for other prime contract awards for other two Regions.

RESPONSE: See responses to Questions 924 and 1346.f.

k. Please identify the factors and subfactors in Section M that the Government will consider in determining which offeror will be awarded a prime contract for the second Region and excluded from consideration for other prime contract awards for third Region.

RESPONSE: See responses to Questions 924 and 1346.f.

l. Section L.13 states that, after selection of prime contractor for the first contract award, that prime contractor will be eliminated from consideration for the award of other Regions. Please explain how the source selection for the second Region will be made in accordance with Section M.3 to the "proposal representing the best overall value to the Government" if the "proposal representing the best overall value to the Government" for the second Region has been eliminated from consideration based on Section L.13.

RESPONSE: See response to Question 1346.f.

m. If, after selection of the prime contractors for the first and the second contract awards, those offerors are eliminated from consideration for the award of the third Region, please explain how the source selection for the third Region will be made in accordance with Section M.3 to the "proposal representing the best overall value to the Government" if the proposal representing the best overall value to the Government for the third Region has been eliminated from consideration based on Section L.13.

RESPONSE: See response to Question 1346.f.

n. Will the Government eliminate, from consideration for award, any proposal that is outside the competitive range for technical proposal scores?

RESPONSE: This question is not clear. The "competitive range" refers to overall proposals—see FAR 15.306(c). There will be no "competitive range" solely for technical proposal scores.

o. Will the Government eliminate, from consideration for award, any proposal that is outside the competitive range for past performance proposal scores?

RESPONSE: There will be no "competitive range" solely for past performance proposal scores. See the response to 1347n.

p. Will the Government eliminate, from consideration for award, any proposal that proposes a price that is outside the competitive range for proposed prices?

RESPONSE: There will be no "competitive range" solely for proposed prices. See the response to 1347n.

q. Will the Government eliminate, from consideration for award, any proposal that proposes a price that is determined by the Government to be unreasonable?

RESPONSE: The hypothetical contains insufficient information on which to speculate as to the actions available to the Government. The Government can not say with certainty what action it might or might not take. For example, it is possible that, in the scenario given, the government might choose to engage in discussions in an attempt to clarify the "unreasonable" price. However, other actions are possible depending on all the facts.

r. Will the Government eliminate an offeror from consideration for award of a Region (because that offeror will be awarded another Region) and award the contract to a second-ranked offeror if that second-ranked offeror has proposed a technical proposal that has been determined by the Government to be marginally acceptable

or unacceptable? If no, please explain how the source selection for that Region will be made in accordance with Section M.3 to the "proposal representing the best overall value to the Government" if the contract is awarded to an offeror that has proposed a technical proposal that has been determined by the Government to be marginally acceptable or unacceptable.

RESPONSE: The Government can not say with certainty what action it might or might not take. For example, it is possible that, in the scenario given, the government might choose to engage in discussions in an attempt to clarify the "marginally acceptable" or "unacceptable" technical proposal . However, other actions are possible depending on the all the facts. See response to Question 1346.f. regarding selection of proposals for award by the Source Selection Authority.

s. Will the Government eliminate an offeror from consideration for award of a Region (because that offeror will be awarded another Region) and award the contract to a second-ranked offeror if that second-ranked offeror has proposed a price that has been determined by the Government to be unrealistic or unreasonable? If no, please explain how the source selection for that Region will be made in accordance with Section M.3 to the "proposal representing the best overall value to the Government" if the contract is awarded to an offeror that has proposed a price that has been determined by the Government to be unrealistic or unreasonable.

RESPONSE: See response to Question 1347.s.

1348. Objective 5 requires the contractor to provide "Ready access to contractor maintained data" and Sections C-7.37 and C-7.31.1 require the contractor to furnish access to claims data and TRICARE-related data to MTFs, The Surgeons General, the Regional Directors, Health Affairs and TMA.

a. How will the government be assured that the individuals who receive access to the claims data and the TRICARE related data only access that information for which they have a need to know? Also, as examples, please address how an MTF will be prevented from accessing data that does not pertain to that MTF and how the Army Surgeon General will be prevented from accessing claim data or personal health information pertaining to Navy or Air Force beneficiaries.

RESPONSE: Access by individuals will be limited to those who are screened by TMA and determined to have the appropriate clearances and have a need to know in the performance of their official duties.

b. Will the government indemnify the contractor for any violations of the Privacy Act or HIPAA caused by the government individuals who have access to protected data?

RESPONSE: The contractor continues to have responsibility under the Privacy requirements to assure that personal information about individuals is limited to that which is legally authorized and necessary.

1349. Will the government please provide a description of the room to be used for the oral presentations? Room size, lighting, etc. would be helpful.

RESPONSE: That information is not available at this time. Offerors may be advised of this information when they are notified of the time and location of their oral presentation.

1350. The Government clarified the MCS contractor's access to pharmacy data in responding to Question 1230 with the following information: "The Government will provide TRICARE program data in response to requests that establish a need to know in furtherance of contract performance by Managed Care Support (MCS) contractors in their medical management practices. Such data release will be subject to execution of data use agreements which will ensure use of the data in accordance with law, regulation, and policy and which will address the procedures, costs, etc., involved. The data will be supplied from the Government's own data bases to the MCS contractors, and not directly from the other contractors. The Government agrees to cooperate with the MCS contractors, in consultation with the other TRICARE contractors, post-award during the Transition Period to establish the minimum data the MCS contractor will require and to ensure protection of proprietary information of all contractors."

We request that this clarification be incorporated into the next Amendment to the RFP.

RESPONSE: We do not believe it is necessary to incorporate this into the RFP and ultimately the contract.

1351. Reference RFP Section M.8 and M.9
The Government is making a distinction between the evaluation of price and the evaluation of cost, and in doing so has stated in section M.5.b, that price is more important than cost.

a. In the evaluation of cost, as detailed in section M.9, are we correct in our understanding that the Government may make adjustments to the offerors cost for option period I, based on data that reflects the Government's best estimates, and this adjusted cost will be know as the probable cost, and will be used for Option year I Health Care Cost and Underwriting Fee evaluation purposes?

RESPONSE: Yes.

b. Do we understand correctly that Underwriting Fees for Option years II through V are part of the price evaluation, but that Underwriting Fees for Option year I are considered part of the cost evaluation? If correct, can the Government please explain why it considers Underwriting Fees to be cost for one evaluation and price for another, and then make one more important than the other?

RESPONSE: The underwriting fee is directly related to target health care costs. Since target health care costs are proposed and evaluated for Option Period I, the Government will evaluate the impact of any cost realism adjustments on the underwriting fee in determining the probable cost in accordance with the underwriting fee adjustment formula detailed in Section H.1.b.(5) of the RFP. For Option Periods II through V, no target health care costs are proposed or evaluated; therefore, the proposed underwriting fees are fixed and properly evaluated as part of the total evaluated price. For the purpose of the source selection decision, the Government has determined that total evaluated price is more important than the probable cost plus underwriting fee.

c. Will adjustments the Government may make to the offerors health care cost be based on trend factors between the data tape base years and the Option I period

start of healthcare? If yes, will the Government share its trend factors with the prospective offerors?

RESPONSE: The Government will evaluate an offeror's assumptions in their cost buildup. Offerors have the responsibility of supporting their trend assumptions regarding the change to health care costs from the data tape base years to the start of Option Period I health care delivery. The Government does not have a predetermined set of trend factors that will be used but may adjust an offeror's cost to a realistic range if the offeror's trend assumptions are found to be unrealistic.

d. Are we correct in our understanding that the Government will not add the results of the M.9 probable cost to the M.8 price for evaluation purposes?

RESPONSE: Yes.

e. Will the results of the M.8 cost evaluation be given a score in comparison with other bidders? If yes, please explain the scoring methodology. If no, please explain the evaluation scoring methodology.

RESPONSE: Neither price nor cost will be scored. The total evaluated price and probable cost calculated for each offeror will be considered in the source selection process. The Government will use a tradeoff process in determining the best value, which permits tradeoffs among probable cost, total evaluated price and the non-cost factors and allows the Government to award to other than the lowest priced proposal.

f. Will the results of the M.9 price evaluation be given a score in comparison with other bidders? If yes, please explain the scoring methodology. If no, please explain the evaluation scoring methodology.

RESPONSE: See response to 1351.e. above.

1352. Reference The Class Deviations From FAR and response to Question 490 Page 5 of the Determinations and Findings (D & F), last paragraph states, "The target health care cost for the first option year will be established through the competitively negotiated offers in response to the RFP." Does this D&F prevision imply the Government will conduct post award negotiations of the health care cost for the first option year? If yes, will the Government amend the RFP?

RESPONSE: No.

1353. Reference The Class Deviations From FAR and response to Question 490 Page 6 & 7, Analysis of Deviations: The Government has articulated several significant points concerning the contractors limited ability to control health care cost. Further the D & F states, "As a result, the ability of the contractor (or the Government) to project health care costs for all option periods is very problematic. TMA believes that the ability of cost realism evaluators to project health care costs over five option years is so limited, given all the attendant variables, that any projected probable costs would be impracticable and subject to great uncertainty." Given these facts:

1. This analysis and the points the Government has made regarding problematic ability to predict future health care costs, and the fact the Government is relaying on the approval of this Request for Class Deviations from FAR to conduct this procurement, and,

2. The Government has issued Amendment 0006, modifying the evaluation of Price/Cost of this solicitation. The Government has established two distinct evaluation factors, M.8 Evaluation of Price and M.9 Evaluation of Cost, we have the following questions:

a. In Section M.8 Evaluation of Price, offerors Total Evaluated Price will include Administrative Support Services and Underwriting fees for option periods II through V. Since the calculation of underwriting fees are a product of estimating future years health care cost, which as stated in the D & F findings are problematic and the ability to perform a cost realism over five years is limited. The impact of including these option years Underwriting Fees for evaluation of price may skew and artificially influence the award of this evaluation factor. In consideration of the approved Class Deviations from the FAR, will the Government reconsider the factors currently present with RFP Amendment 0006 for evaluation of Price?

RESPONSE: No, the Government does not intend to amend the solicitation.

b. In section M.9, Evaluation of Cost, offerors proposed Option Period I health care cost and underwriting fee will receive a cost realism analysis. The Governments cost realism analysis may adjust the offerors proposed health care cost to reflect the Government's best estimate of the cost that is most likely to result from the offeror's proposal.
The detailed analysis of the D &F, clearly states; "TMA believes that the ability of cost realism evaluators to project health care costs over five option years is so limited, given all the attendant variables, that any projected probable costs would be impracticable and subject to great uncertainty."

In consideration of the approved Class Deviations from the FAR, will the Government reconsider the factors currently present in the RFP Amendment 0006 for evaluation of Cost?

RESPONSE: No, the Government does not intend to amend the solicitation.

1354. Reference The Class Deviations From FAR and response to Question 490 Page 8 Deviations from FAR 52.216-10(b)(1) - The first paragraph, last sentence in this section states: "The underwriting fee for each option period will be fixed at initial award based on the competitive offerors in response to the RFP."

RFP Section H.1.b.(3) Target Underwriting Fee page H-2.states: "When the parties negotiate the target cost for option period II and/or subsequent period, the parties will apply the fee percentage proposed at contract award (for the relevant time period) to the negotiated target cost to determine the actual target fee. In the event the parties are unable to negotiate the target cost for option period II and/or subsequent period, the target underwriting fee will be the dollar amount established at contract award."

The D&F does not make the distinction between ability to negotiate target cost for application of underwriting fee. Please clarify which approach is correct, the D&F or the RFP.

RESPONSE: There are no errors in the referenced D&F or RFP paragraphs. If this question implies there is an inconsistency between the D&F or the RFP, we disagree.

1355. Reference The Class Deviations From FAR and response to Question 490 Page 10, Deviations from FAR 52.216.7 - Section 1 which states: "The frequency of payments should be changed from not more than once every 2 weeks (FAR 52.21.6.7 (a)) to every business day. This will decrease the financial burden upon the contractor. Each contractor will pay out an enormous amount of health care costs on a daily basis. The Government wishes to avoid paying any additional costs for interest that would occur if the payments to the contractor were not immediately reimbursed."

a. RFP section G-3 a. Contract Payments Disbursed by TMA Aurora, Subsection [j] states: "General Description. Payment of underwritten health care cost claims will be made to the Contractor within five business days after the associated TEDS records clear all edits." Will the Government clarify the inconsistent payment terms for Underwritten Health Care Costs? Will the Government follow the approved D&F and pay daily? Will the Government amend this RFP to reflect the approved payment terms of the D&F?

RESPONSE: : The Government does not intend to change the solicitation. The Government has already incorporated daily payments as allowed by the D&F . The cost-reimbursement payments, made within five business days, will in fact be made on a daily basis assuming that the contractor has made daily submissions which clear the required edits. The D&F and the RFP are not inconsistent.

b. RFP Section G-3 Contract Payments Disbursed by a Military Treatment Facility (MTF) through the Defense Finance and Accounting Services (DFAS). Subsection (d) states: "The contractor will be paid by the MTF in accordance with the Prompt Payment Act." Will the Government clarify the inconsistent payment terms for MTF direct care costs? Will the Government follow the approved D&F and pay daily? Will the Government amend this RFP to reflect the approved payment terms of the D&F?

RESPONSE: The Government does not intend to change the solicitation.

1356. In conjunction with the claim data tapes for T-NEX South, the bidder has reviewed both the existing TRICARE Reimbursement Manual (6010.53-M) dated 3/15/02 and the T-NEX TRICARE Reimbursement Manual (6010.55-M) dated 8/1/02 to understand TRICARE non-network reimbursement. Specifically, we have compared the reimbursement guidelines related to Hospital Reimbursement - Outpatient Services, which is Chapter 1, Section 25 and Chapter 1, Section 24 respectively. The T-NEX version appears to provide more situations in which a method other than billed charges can be used for reimbursement of non-network hospitals. However, in reviewing the claims data, there is an appearance that some payment methodologies available for T-NEX may have already been implemented. In order to determine the potential for healthcare cost savings over and above the Government provided claims data, it is important for a bidder to understand if the reimbursement policy is new or has already been implemented. Accordingly, we have the following questions based on a non-network hospital situation:

[a] TRICARE Policy states that a CMAC rate can be used for certain outpatient hospital services. It is this bidder's understanding that those services that have both a technical and a professional component (i.e, radiology, pathology, EKGs, EEGs, certain cardiac procedures, etc.) readily fall into this category. Other services that are technical only (i.e., laboratory, physical therapy, etc.) can also readily apply CMAC pricing. Does the Government agree with this statement?

RESPONSE: Hospital facility services that would not have a billable HCPCS code would be paid as billed. At the present time TRICARE does not have allowable charges for facility services. If the service has a billable HCPCS code i.e., laboratory, physical therapy, etc. then payment is to be made based on the allowable charge, i.e., CMAC. Technical by definition would be associated with a diagnostic procedure or test.

[b] The use of CMAC rates for certain other outpatient hospital services like emergency room and anesthesia would not be appropriate. Physicians are paid for their professional service (i.e., evaluating the patient or administering the anesthesia), which are billed on a HCFA-1500. The hospital (or other facility which is not the physician's office) bills for the use of its emergency room space and equipment or the gases/drugs and equipment used to administer the anesthesia, which are billed on a UB-92. Does the Government agree with this statement?

RESPONSE: Assuming that all professional services [i.e., emergency room physicians and anesthesiologists and certified nurse anesthetists (CRNAs)] are billed on a HCFA-1500, then the remaining facility services billed on the UB-92 are to be paid as billed. A hospital may select either the UB-92 or the HCFA 1500 to bill for professional services, ambulatory surgery, ambulance services, durable medical equipment, oxygen and supplies, injectable drugs etc. It makes it easy when the hospital selects the HCFA 1500 to bill for these services (including the technical component of a diagnostic professional service) and uses only the UB-92 to bill for facility charges.

[c] In regard to non-network hospital emergency room services provided in an outpatient hospital setting and billed on a UB-92, what TRICARE reimbursement methodology currently in effect creates an allowable that is less than billed charges?

RESPONSE: Any service that has a TRICARE established allowable charge and billed on a UB-92 would not be paid as billed. This would include ambulatory surgery services, professional services (including anesthesia services), ambulance services, injectable drugs, durable medical equipment, oxygen and supplies, etc.

[d] In regard to non-network hospital anesthesia services provided in an outpatient hospital setting and billed on a UB-92, what TRICARE reimbursement methodology currently in effect creates an allowable that is less than billed charges?

RESPONSE: See the response above. Also, network hospitals operate under an agreement with the managed care contractors may have negotiated discounts which affects the payments. Non-network hospitals do not.

1357. In conjunction with the claim data tapes for T-NEX South, the bidder has reviewed both the existing TRICARE Reimbursement Manual (6010.53-M) dated 3/15/02 and the T-NEX TRICARE Reimbursement Manual (6010.55-M) dated 8/1/02

to understand TRICARE non-network reimbursement for ASCs. Specifically, we have compared the reimbursement guidelines related to Ambulatory Surgical Center Reimbursement (applicable to both ASCs and hospitals), which is Chapter 9, Section 1 in both manuals. Accordingly, we have the following questions based on a non-network hospital or free standing ASC situations:

[a] Previously, Chapter 9, Section 1, III. A.5.b. did not allow payment of services to a freestanding ASC unless the surgical services were identified on Addendum A. While most surgical services not in Addendum A have traditionally required a hospital setting to be performed, relatively minor surgical services not in Addendum A now performed in a physician's office could be performed in a facility (ASC or hospital outpatient department) which result in an additional bill and higher overall costs to TRICARE. How does the Government expect the bidder to enforce Chapter 9, Section 1, III.B, which prohibits the "cost sharing" (payment of a benefit) of a surgical service not in Addendum A unless doing so results in no additional costs to TRICARE?

RESPONSE: Contractors have the authority to reimburse procedures that are not in Addendum A as ambulatory surgery, even when performed in a freestanding ambulatory surgery center. It has been left to the contractor's best business practices to determine which procedures to reimburse under this authority and the reimbursement rate for such procedures. Presumably, a contractor would reimburse procedures under the most economical process and not choose to use ambulatory surgery payment rates for a procedure that normally would be provided in a physician's office.

[b] In today's claims data tapes, under what TRICARE reimbursement policy are some non-network surgical services not in Addendum A paid on a basis other than billed charges?

RESPONSE: This would occur under the authority referred to in 1357(a) above.

1358. Section F.4 of Amendment 0006 for the North states "... the Scott Air Force Base catchment areas of Missouri..." and the West states "...Missouri (except for those zip codes which have been assigned to MCSS, North Region)." The existing MCS Contract for Regions 2&5 included a listing of 108 zip codes designated as a Prime requirement area for St. Louis, MO according to Section J-3, Attachment 16 of Amendment 0014. These same zip codes have not been designated as a Prime requirement for T-NEX, as the zip codes are not Catchment to Scott AFB and are not part of any Clinic MTF.

[a] Is it the Government's intent to move these current Region 5 zip codes for St. Louis, MO from the North Region to the West Region under T-NEX?

RESPONSE: No. The current Region 5 zip codes that extend past Scott AFB catchment area into Missouri will be in the North Contract in addition to the catchment area Missouri zip codes. Missouri zip codes outside the catchment area are not considered part of the Prime service area. Because over time the Post Office has changed or deleted/added zip codes here are the current non-catchment area Missouri zip codes:

Saint Louis Prime Service Area Zip Codes (Non-Catchment)

63001 *	63060	63336	63365 *

63005	63061	63338 *	63366
63013	63066 *	63339	63367
63014	63068	63341	63369
63015	63069	63342 *	63370 *
63016	63071	63343	63376
63020	63072	63344	63377
63023	63073 *	63345	63378 *
63025	63077	63346 *	63379
63028	63079 *	63347	63381
63030	63080	63348	63382
63036	63084	63349	63383
63037	63087	63350	63384
63038	63089	63351	63385
63039	63090	63352	63387 *
63040	63091	63353	63388
63041	63304	63357	63389
63047 *	63330	63359	63390
63050	63332	63361	65041
63055	63333	63362	
63056	63334	63363	

* = Post Office Box

[b] In response to Question #157, the Government previously affirmed that no changes in the boundaries of the existing MCS Regions was intended. However it appears that they will be changing. Is a separate transition piece now required?

RESPONSE: Question 157 concerns downsizing of MTFs, not moving boundaries. We are not sure what question and answer you are referring. The intention of the government is not to change current boundaries; e.g. zip codes previously carved out of Missouri and placed in the current Region 5 will remain with the North Region.

1359. Question # 1079 regarding "serious errors in the data you have provided for Prime Non-Catchment area zip codes for Region 1" was posted on 10/18/02. On 10/31/02, the Government responded that "New information will be provided as soon as possible." On 11/20/02, the Government responded on the same issue to Questions # 1179 and 1211 that ..."We have obtained a new data set and are attempting to verify the accuracy. We will provide new data to offerors based on the information available to the Government." With the proposal due date approaching, accurate data is needed to facilitate decisions on "voluntary" Prime benefit offerings on T-NEX North and to minimize the incumbent Contractor's inherent competitive advantage, despite their apparent inability to define the existing Non-Catchment Prime offering in previous attempts.

[a] When will this revised information be available?

[b] Has this bidder somehow overlooked a delivery subsequent to 11/20/02?

RESPONSE: We released another revised Region 1 Prime Non-catchment area zip code file to bidders via FedEx on 12/13/02. Please use this version.

1360. In response to Question # 1128a, the Government stated that "The waivers eliminate the application of access standards to beneficiaries residing outside Prime

Service Areas." Since T-NEX Prime offering requirements are less in some areas (i.e., St Louis , MO; Cleveland, OH, Albany, GA; etc.), waivers will not exist. In addition, Prime beneficiary relocation has allowed some beneficiaries to enroll and then move out of the Prime offering area by small and sometimes large distances. By practice, a Prime enrollee who moves farther away and does not disenroll has waived the access standard.

[a] Does any record exist of Prime Enrollees with existing waivers?

RESPONSE: TMA does not maintain those records.

[b] Will the new Contractor be required to contact all Prime beneficiaries more than 40 miles distant from a T-NEX Prime Offering area/PCM to sign a waiver?

RESPONSE: No.

1361. The Government requested clarification to Questions # 1142a, 1142b, 1142c, 1143a, 1143b, and 1143c. The questions were intended to ensure agreement on reporting requirements when T-NEX Required Prime Offering areas overlap by creating an agreed upon hierarchy (priority) of Prime coverage areas based on the entity causing the Prime coverage requirement. This overlap occurs when one or more Hospital MTFs, Clinic MTFs, and BRAC sites have the same (or share a large number of the same) geographic zip codes. Historically TRICARE/CHAMPUS reporting has been based on geography. Specifically, data separately for each Catchment area (Hospital MTF) and data for all other zip codes in a state rolled up to a single Non-Catchment summary. For Prime beneficiaries, some reporting could be based on PCM assignments, as is done in commercial HMOs. However, TRICARE has never required this type of reporting. Further, this new requirement would not accommodate non-Prime beneficiaries. Please explain how future T-NEX reporting for enrollment, network adequacy, referrals, etc. should be categorized.

RESPONSE: The network adequacy report, the referral report, and the 2 enrollment reports will continue to be based on geography. (TOM, Chapter 15, Section 3)

1362. If it is TMA's intent to have all physician reviewers in active practice, we request that you consider the following:
Allowing the contractor to have doctors on staff to perform the reviews provides consistency with TRICARE policy. When the physicians are on staff we are able to provide intensive training on policy, thus being able to ensure benefit and medical necessity issues are addressed completely. Expecting that only doctors in active practice do reviews, is a burden on the providers as they must work the reviews into already busy schedules. We believe that this may lead to areas of inconsistency, as the MCSC would be required to use physicians in many different geographic locations to perform the initial reviews. Timeliness would be impacted as the providers would have to perform the reviews along with their practices, and allowing for the time to send and receive the case information would significantly decrease the time the MD would have to perform the review. Significant expense would be involved in not only the physician reimbursement costs, there would also be cost to mail (overnight) and copy the case records.

RESPONSE: Thank you for your comment; however, there are no plans to change this requirement. The desire is to obtain an independent review.

1363. We are under the assumption that the HIPAA compliant message coming from the MTF provider will be complete.
Will the following information be present for the MCSC:

1)Required CPT4 procedure codes
2)ICD-9 diagnosis codes
3)Number of visits and the time frame for the visits
4) Scope of the care, is the patient being referred for evaluation only, or for evaluation and treatment, or for a procedure?
Please confirm that the transmission from the MTF will contain all this information?

RESPONSE: The transmission from the MTF will contain the above information. The Enterprise Wide Referral and Authorization System (ERAS) will send to and receive from the T-NEX MCSCs, HIPAA compliant ANSI ASC X12N 278 transactions. For all of the data elements and code values that comprise the ANSI ASC X12N 278 transaction, please refer to the HIPAA Implementation Guide.

1364. In Chapter 12, Section 1, 4.2, please clarify the term "all providers." Does it include network providers, non-network providers, non-network providers who have filed claims? We must have contact information on non-network providers in order to effectively distribute the quarterly provider newsletters and monthly bulletins.

RESPONSE: All providers that have been certified as TRICARE-authorized providers and are on the provider file as an active provider (TOM, Chapter 4, Section 1, paragraph 2.5)

1365. In developing a solution for complying with the requirement for consult report to be delivered in a ten day timeframe there are a few issues we would like to comment on:

This will be a costly solution to a problem which may be best resolved by a multi-contractor quality improvement task force.
This task force would focus on the root cause for the MTF dissatisfaction with the return to consult reports and directing the solution by performing a root cause analysis. This may be more of an issue of how or where the reports are delivered rather than if it is being delivered at all. Instead of expending the funds to develop a complex system, we would like to give the contractor the opportunity to work at a root cause solution to their issue. Is this possible?

RESPONSE: There is nothing to keep contractors from proposing suggested improvements.

1366. The HCSR data provided show dramatic differences in FY02/FY01 per eligible trends by region. Has the government analyzed the cause(s) of these dramatic differences?

RESPONSE: No. We are aware of the trends but have not analyzed any data.

1367. Will the government provided updated claims information through the third quarter of 2002? Emerging trends are extremely high, perhaps driven by unusually low costs in September, 2001.

RESPONSE: No future updates to the claims data are planned.

1368. Response to Question 645 indicated that the government has examined the value of existing (old) Resource Sharing contracts. Where these old agreements have value, TMA is providing the Surgeon's Generals with the funds to continue these through other means.

Has the government completed the process to determine which of the old agreements have value and therefore continued through other means or will this process occur after contract award through the transition process?

RESPONSE: Activities are occurring internally to the DHP to determine the time frames and mechanism to transfer these funds and the funds will be transferred in sufficient time for the MTF to purchase the desired resources.

1369. Since the Contractor will be reimbursed for healthcare dollars and receive a claim rate for EMC and paper claims based on accepted TEDs records, will the government be providing an electronic detail claim payment file along with each payment made to the Contractor? Such a file will be needed so that the Contractor will be able to reconcile its internal records to the payments made by the government.

RESPONSE: This is a two part process. The contractor office submitting TED records will be provided with an electronic record of all TED records which are not accepted as well as those which are accepted only provisionally and which need corrections. This part of the process deals with the TED submission and acceptance process. CRM shall also provide to the contractor's accounting office a detailed claim payment file via the TMA, CRM web page. All claim payment information from CRM will be posted to this web page and can be used by the contractor, in conjunction with its data submission records, to reconcile its internal accounting records.

1370. Section M.1 states, "For the health care contract line item number (CLIN), the government will evaluate offers, for award purposes, by including only the price for Option Period 1; i.e., Option Periods 2-5 will not be included in the evaluation for award purposes."

Section M2 states, "For all contract line item numbers (CLINs), except for health care, except when it is determined in accordance with FAR 17.206(b) not to be in the Government's best interest, the Government will evaluate offers for award purposes by adding the total price for all options to the total price for the basic requirements."

What is the government's intent for evaluating proposed non-required initiatives that will reduce cost of care in all years and will entail five years of additional administrative costs.

RESPONSE: Offerors are not to propose health care costs for Option Periods II through V. Therefore, any projection of future year health care cost savings will not be proposed or evaluated. Administrative costs for any programs, processes or procedures in accordance with an offeror's technical approach shall be included in the administrative prices and will be evaluated as detailed in RFP section M.8. Section M.2. of the RFP pertains only to evaluation of the administrative CLINs for purposes of exercising options. It does not pertain to health care CLINs. Offerors are reminded to review the supplemental information for Questiop 490 posted on the

Questions and Answers area of the solicitation website. This document provides discussion and authorization of the Government's treatment of health care costs.

1371. M-9.c., as of Amendment 0006, states, "Results of this analysis . . . may be used by the Contracting Officer in making a responsibility determination." We have the following questions:

a. What specific elements of the analysis affect the responsibility determination?

RESPONSE: Guidelines in determining responsibility are in the Federal Acquisition Regulation, Part 9.

b. To what standards of responsibility will those elements be applied?

RESPONSE: Please refer to Part 9 of the Federal Acquisition Regulation for guidelines in determining responsibility.

1372. L-14.e.(4), as of Amendment 0006. In its response to question 413, the Government indicated that it would provide a file of network provider directories so that offerors could determine what percentage of existing network providers will continue to be network providers. With just over one month left before submission of the proposals, when does the Government intend to provide these directories so offerors have information on which to base their proposals?

RESPONSE: The Government, after a re-review of the current network provider directories that are furnished to the public, has decided some are too dated to be of use. The Government has no current listing available; therefore we recommend using the incumbent's web site.

1373. Attachment L-12, as of Amendment 0006. The new attachment is very helpful; thank you. We have these questions:

a. Does the Government intend to use this outline for its evaluation of the oral presentation?

RESPONSE: We only offered this as a guide to assist the offerors in structuring their proposals.

b. Does the Government intend to use this outline for its evaluation of the written proposal listing standards?

RESPONSE: We only offered this as a guide to assist the offerors in structuring their proposals.

c. If the answer to b. is no, would it be helpful if offerors organized the written proposal by Contract Line Number, in order of appearance in the various manuals or RFP, or some other method?

RESPONSE: That is left up to the discretion of the offeror.

1374. Under this solicitation, will contractors be required to reimburse hospitals for outpatient facility claims at the established outpatient TMAC rate, where a TMAC exists?

RESPONSE: Please see the answer to question 1356.

1375. The Government recently sent updated procurement data files to interested parties who had purchased the data tapes. One of the files, "Region 1 Prime Non-Catchment Nov 2002 update.xls" is confusing. It appears that the file shows ZIP codes outside of Prime Service Areas where the current contractor has network providers. The file does not appear to show additional non-catchment Prime areas. Please clarify the contents of this file for offerors.

RESPONSE: We released another revised Region 1 Prime Non-catchment area zip code file to bidders via FedEx on 12/13/02. Please use this version.

1376. L.12.e. This RFP section indicates that all submissions are to be electronic. In questions and answers, the government has indicated that this is without exception and that it prefers PDF format for large attachments. However, L.12.e requires the submission of information in a Microsoft Office 97 application. PDF files are Acrobat, not Microsoft. The RFP has not been modified to allow for the submission of PDF files. As indicated in an earlier question, some proposal attachments may be several hundred, if not thousand, pages long. If PDF is not allowable, the documents would need to be scanned into MSWord and then hundreds of hours spent cleaning up the errors that occur in such transactions. Can the government please modify the RFP to allow the submission of PDF/Acrobat files?

RESPONSE: PDF files are acceptable for past performance only as amended in Amendment 7. As a secondary note, we are not expecting a thousand pages, so one may review Section L before submitting that many pages.

1377. Section L-14 f. (4) (i) [1] of the RFP states that "[f]or the West contract, offerors shall provide two separate proposals." Since the only difference between the two proposals requested in the inclusion or exclusion of underwritten health care services for Alaska residents, please clarify what will be required to satisfy this directive. For example, could the "proposal" excluding Alaska consist simply of a summary pricing sheet with Alaska omitted but supported by the same set of documents and exhibits as the proposal including Alaska? Or could the proposal including Alaska include only discussion of the pricing for that area and refer to the proposal excluding Alaska for the documentation of the rest of the West Region?

RESPONSE: The Government expects two separate stand alone cost proposals. Offerors are to follow the instructions as stated in the RFP. Note that the quote included in the question above is not an exact quote from the referenced paragraph.

In other words, does the Government insist on duplicate copies of the supporting papers and files in these situations so that the two "proposals" can read totally independently? Or can an offeror be responsive to this requirement by entering a bid for both of the referenced CLINs and supplying adequate documentation in support of the proposed amounts? Please provide your explicit comments on exactly what is expected here.

RESPONSE: The Government expects two separate stand alone cost proposals. Offerors are to follow the instructions as stated in the RFP.

1378. Section L-14 f. (4) (i) [3] of the RFP provides a list of "minimum" requirements for narratives or analyses supporting an offeror's pricing assumptions. Please clarify what is considered adequate to "address their consideration" of the specified items.

For example, an offeror may make no adjustment to the proposed cost for assumed changes in MTF workload levels. Would a statement to this effect be sufficient documentation of the assumption, even though no quantitative expected workload has been specified? The same question can be applied to other assumptions as well, e.g., other health insurance.

Also, can the listed issues be combined? For example, must the matters of intensity of services and per unit price inflation be addressed separately, or can a combined assumption be presented as covering both of them? Please give clear direction on what is required for each of the indicated items.

RESPONSE: The RFP states, "Offerors shall provide narratives and/or quantitative analyses supporting the specific assumptions used to develop the target cost. At a minimum, offerors shall address their consideration of the following issues in the cost proposal." What this means is that the offerors should present sufficient information, whether narrative and/or quantitive, in a manner that the evaluator can follow and understand how the offeror considered each point. The Government cannot tell offerors how to specifically prepare their proposals.

1379. In §L-14 f. (4) (i) [3] of the RFP, the Government requests that offerors specify "the percentage of total care subject to assumed discounts." If an offeror believes and documents that provider discounts and the level of network utilization will remain unchanged, this percentage may not be a relevant pricing consideration. Please explain why the Government is insisting that an explicit assumption be presented for this factor, regardless of its import in development of the target cost. Or will the Government delete this requirement since it may not be relevant to all bidders?

RESPONSE: CMCP If an offeror adequately describes their assumption that a factor will "remain unchanged", then the requirements of Section L will have been met.

1380. If an offeror assumes that MTF workload will increase or decrease in Option I (from historical levels), it will be necessary to estimate the numbers of CHAMPUS services that will shift into or out of the military facilities. Please provide any Government data or estimates regarding the relationship between MTF and civilian care (e.g., two outpatient MTF visits "replace" one civilian visit, etc.) in as much detail as possible.

RESPONSE: All available Government data has been provided.